the Canadian Nurse

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MONTREAL

FEBRUARY 1963

HIGHLIGHTS

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PRINCIPLES OF MANAGEMENT

JOB SATISFACTION IN HOSPITAL NURSING

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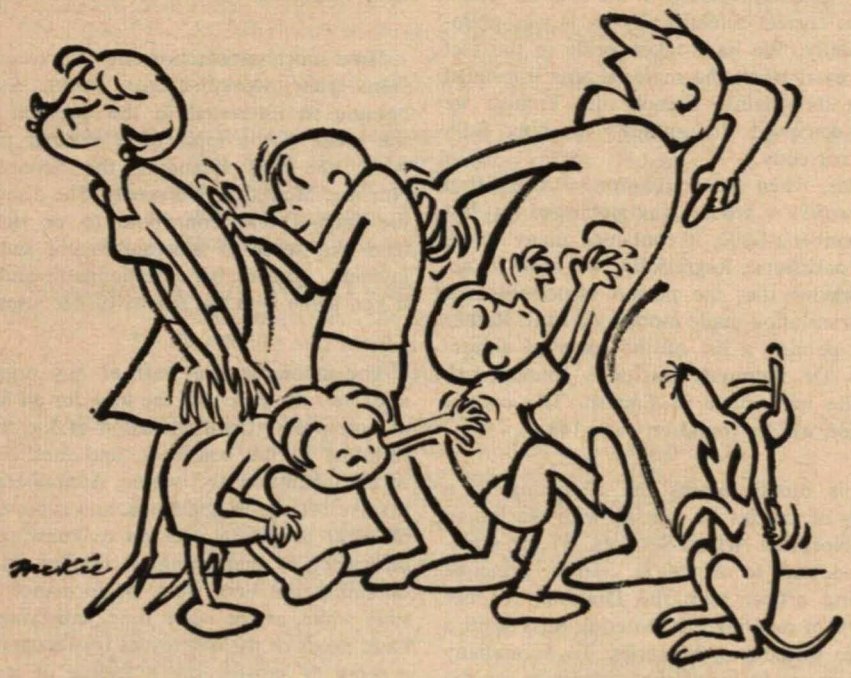

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Between Ourselves

We on the editorial staff have always considered it our duty to make sure that every article published in the *Journal* would be as correct scientifically as it was grammatically. We have taken pride in the fact that even when the material was translated from its original French into English we had conveyed the author's meaning fully and correctly.

Alas, when the translation of DR. MIMI BELMONTE'S article was published in last November's issue, it contained many errors and omissions. Regretfully, we have to acknowledge that the person responsible for the translation made a poor job of it. Rather than publish a list of the essential corrections, Dr. Belmonte graciously consented to rewrite her article in English. The correct version will be found on page 143.

* * *

This month marks the beginning of a series of articles on nursing with the Indian and Northern Affairs Services. We are greatly indebted to ALICE K. SMITH, principal nursing officer with the Division, for her efforts in securing this material. Miss Smith's article introduces the series. To accompany it we have included the description of the health care provided to the Indian people in British Columbia. Unfortunately the author of this presentation, GRACE HARRIS, died early in 1962. Miss Harris was the regional supervisor of nursing for the British Columbia division. In succeeding issues you will read of the health services available to both Indian and Eskimo people of the other regions within the scope of Indian and Northern Affairs.

* * *

What is your conception of your role as a nurse? Is your chief concern simply to get the patient back on his feet and out of hospital or do you feel that your contribution is much more fundamental than this? JAMES K. SKIPPER and RAYMOND E. SAKUMOTO discuss what nurses expect of nurses. They raise some interesting questions. Do you believe, for example, that patients beyond the hope of recovery should receive less attention than others? To what extent should a nurse become personally involved with her patients? These were two of the questions that the authors asked 239 student and graduate nurses. You will be interested in their responses.

* * *

How much satisfaction are you receiving from your work? CAROL ANNE SMITH became so interested in the question that she made it the topic of a seminar paper while she was attending the School of Nursing, McMaster University. She discusses the factors that contribute to or detract from our sense of accomplishment and enjoyment. Answer her questionnaire and see if you agree with the results of her research.

* * *

The administrative staff of any organization sets the pace and the tone for all levels of employees. Disorganization at the top is reflected in the confusion and inefficiency of the institution as a whole. Administration involves direction, guidance, and supervision of other people in addition to knowing the intricacies of budgetting. It implies skill in obtaining the best work performance possible while, at the same time, satisfying the basic needs of the employees for recognition, a sense of satisfaction, a feeling of worthwhile accomplishment and a decent salary. To be a good administrator calls for training and experience. DR. J. PIERRE HOGUE discusses the preparation of this very important group of people in his article on management personnel.

The Nursing Assistants' Association of Prince Edward Island was recently established. This organization has as its objectives:

1. To promote a continuing improvement in the standards and ideals of the licensed nursing assistant.
2. To foster recognition of the status and function of the licensed nursing assistant.
3. To promote close working relationships with other health workers.
4. To promote an educational program.
5. To encourage participation in service groups.

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125 PLASTIC SURGERY ..... *L. R. Cashmar*
Dr. Chasmar, a surgeon in Saskatoon, Sask., delivered this address at a meeting of the Saskatchewan Registered Nurses' Association.

130 NURSING WITH INDIAN AND NORTHERN HEALTH SERVICES ..... *A. K. Smith*
Miss Smith is Principal Nursing Officer, Indian and Northern Health Services, Medical Services' Directorate, Department of National Health and Welfare.

132 HEALTH CARE FOR WEST COAST INDIANS ..... *G. Harris*
Miss Harris was the Regional Nursing Officer for Indian and Northern Health Services, Pacific Region prior to her death last year.

135 TRAINING OF MANAGEMENT PERSONNEL ..... *J.-P. Hogue*
Dr. Hogue who is assistant professor in human relations and psychology and secretary of the *Institut supérieur d'administration hospitalière*, University of Montreal, based this article on an address delivered during a symposium on nursing at the University.

139 THE NURSE ROLE: AN INSTRUMENTAL AND/OR EXPRESSIVE FUNCTION ..... *J. K. Skipper and R. E. Sakumoto*
Mr. Skipper is at Presbyterian-St. Luke's Hospital, Chicago; Mr. Sakumoto is at the University of Hawaii.

143 DIABETES IN CHILDHOOD ..... *M. M. Belmonte*
Dr. Belmonte is assistant, Department of Metabolism, Montreal Children's Hospital, Montreal.

146 NURSING IN HONG KONG ..... *S. Tong*
Miss Tong received her basic nursing education in Hong Kong and came to Canada in 1959. She gave this talk at an RNABC meeting.

147 JOB SATISFACTION IN HOSPITAL NURSING ..... *C. A. Smith*
Miss Smith was a student at McMaster University School of Nursing, Hamilton, Ontario when she prepared this paper.

161 ANOTHER GOAL ACHIEVED ..... *J. Ferguson*
Miss Ferguson is Public Relations Secretary with the CNA

165 HYPOSPADIAS ..... *M. A. Bailey*
Miss Bailey was a student nurse in the Winnipeg General Hospital, School of Nursing when she wrote this article.

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The views expressed in the various articles are the views of the authors and do not necessarily represent the policy or views of THE CANADIAN NURSE *nor of the Canadian Nurses' Association.*

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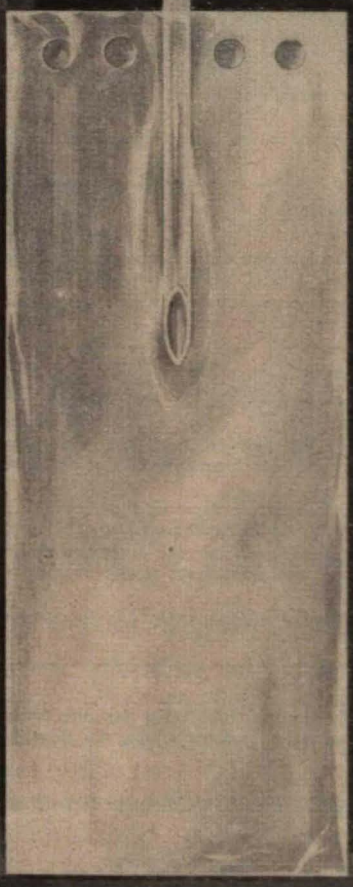

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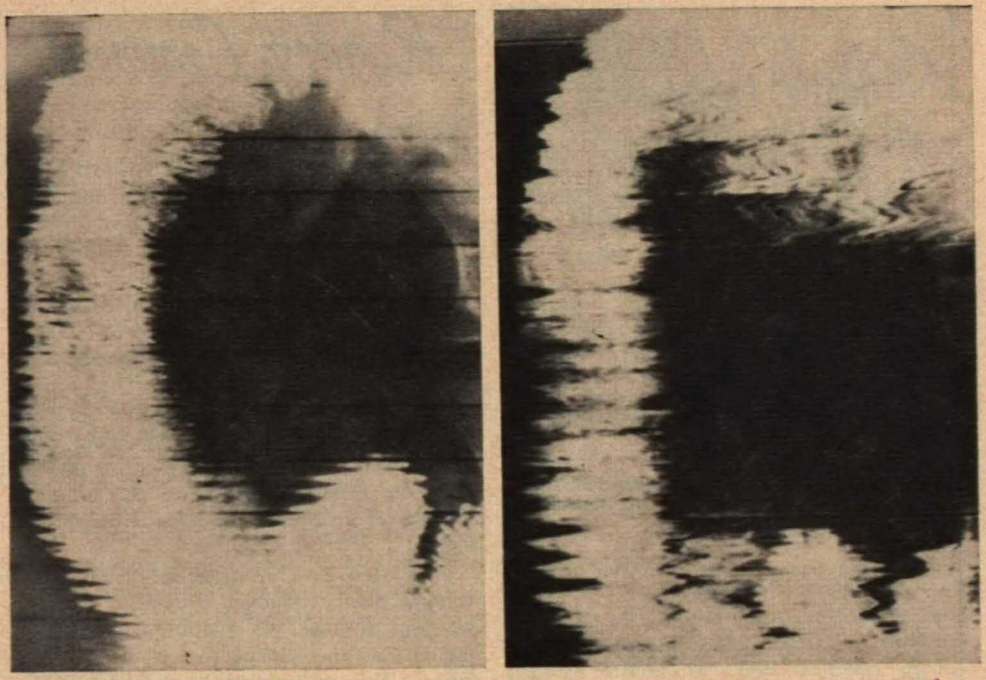
The Journal presents pharmaceuticals for information. Nurses understand that only a physician may prescribe.



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References: (1) Lössl, H. J.: *München. med. Wchnschr.* (supp.) **94**:653, 1952. (2) Birkner, F.: *Wien. med. Wchnschr.* **102**:893, 1952. (3) Bass, E., & Dietrich, H.: *Deutsche med. Wchnschr.* **77**:906, 1952. (4) Schmengler, F. E., & Köster, K.: *Med. Klin.* **47**:121, 1952. (5) Kunz, A.: *Wien. med. Wchnschr.* **103**:305, 1953. (6) Böning, H., & Kirch, A.: *Fortschr. Med.* **70**:351, 1952. (7) Schmidt, J.: *Medizinische* **21**:1293, 1952. (8) Block, A.: *Fortschr. Med.* **71**:202, 1953.

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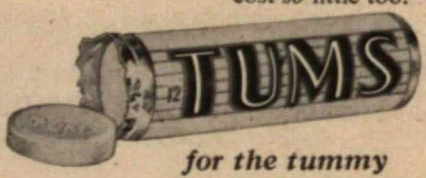

for the tummy

Random Comment

Dear Editor:

As a male State Registered Nurse I have been advocating the equal recognition of male S.R.N.s in the British Armed Forces. The Queen's Commission is granted to female nurses but not to male.

Male nurses have been recognized in the civilian field on equal status for many years now in this country, most appointments being opened to men. The armed forces discrimination has persisted far too long. Not only in this country does this problem arise, but also in Canada. I understand our American colleagues have brought themselves up to date as regards this problem.

A nurse is a nurse, regardless of the nurse being a man or woman. We nurse because we want to nurse, we obtain the same satisfaction — the satisfaction of caring for others. This satisfaction is also obtainable in the services. Servicemen fall sick just the same as civilians, and they need nursing care. Does it matter who gives this care, provided the nurse is a trained nurse? Does it matter if the nurse wears make-up or after shave lotion? With all due respects to our female colleagues, there are many procedures involved which are best suited for the male nurse, and the majority of service patients are men. I am not saying that the men should take the female nurses place in the Services, but please give the men a chance also to share the same privileges bestowed on nurses by virtue of being "Registered." Our female colleagues in this country are behind us. Recently they raised a petition in support of this claim.

As a profession we sadly lack unity. Before unity can be achieved we must have equality.

S. ARMITAGE, England

Dear Editor:

Let me congratulate you on an excellent journal. For the past two years I have been teaching community health. Many times articles contained in the journal were most timely. So please accept my heartfelt thanks.

(MRS.) A. J. BRITTEN, Man.

Dear Editor:

I was unable to attend the June conven-

tion, and therefore appreciated the publication of addresses.

Words and more words! Aside from Miss K. MacLaggan's report I found little that would assist our "lameduck" profession over the stile of how best to educate sufficient nurses, and then to persuade more of them to remain in Canada.

Quoting from the MacLaggan report:

"Any endeavour requiring intelligent people must offer leadership positions."

After reading this and noting the names of a council appointed recently for the College of Nurses, (Ontario), I am emboldened to ask the Ministry of Health for Ontario if Metro Toronto provides all the intelligent leadership in the province. It seems that the same names appear on committees and boards year after year. This is not, in my opinion, an accomplishment to be proud of; nor does it always promote accomplishments.

MARTHA GIBSON, Ont.

Dear Editor:

I am a Certified Nursing Assistant and have found *The Canadian Nurse* to be an excellent source of material for study.

Can I subscribe to your fine publication? Fully realizing that the scope of our work is limited, I find that the more I study and learn, the more interesting my work becomes. My understanding of tests, procedures and patients increases.

(MRS.) LAURA WILLIAMSON, Ontario

Dear Editor:

With sincerity, I would like to express my commendations to *The Canadian Nurse* magazine. It is really quite educational for each nurse to read. I intend to donate my old copies to a school of nursing here in Chicago.

LERNIDA CRUZ, Illinois

Dear Editor:

The secretary of the Ontario Hospital Nurses' Alumnae Association of Kingston, would like to hear from nurses who hope to attend the 1963 reunion. There will be a tea at Embley House on the evening of June seventh; a dinner at six p.m., June eighth; a tea and tour of the hospital on June ninth. Please address correspondence to **Mrs. E. McAvoy, Box 427, Kingston, Ont.**

(MRS.) DOROTHY FERGUSON, Ontario

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I have enjoyed receiving *The Canadian Nurse* during the past year. This was given to me as a gift subscription from a pen-pal in Saskatchewan.

I am a triple certificate nurse, and work at The Women's Hospital in Sydney. The Journals that I have received have been handed around to other members of the staff.

ROSEMARY SMALL, Australia

Dear Editor:

I was very pleased to receive my gift subscription to *The Canadian Nurse*. I am certain that in reading the issues I will gain much valuable knowledge.

I deem it an honor to be the recipient of such an award. Please convey my thanks to the Journal Board.

JEAN LANGLANDS, British Columbia

The world has some 10 million cases of leprosy but only 20 per cent of them receive treatment of any kind according to the World Health Organization. Yet sulfone drugs provide effective treatment, particularly if the disease is diagnosed early.

— *International Nursing Review*, August, 1962.

* * *

The Manitoba Association of Registered Nurses has donated $5,000 to the Canadian Nurses' Foundation Fund. The Manitoba contribution was made in recognition of the 50th anniversary of the MARN that will be celebrated this year. The sum represents $100 for each of the Association's 50 years as a corporate body.

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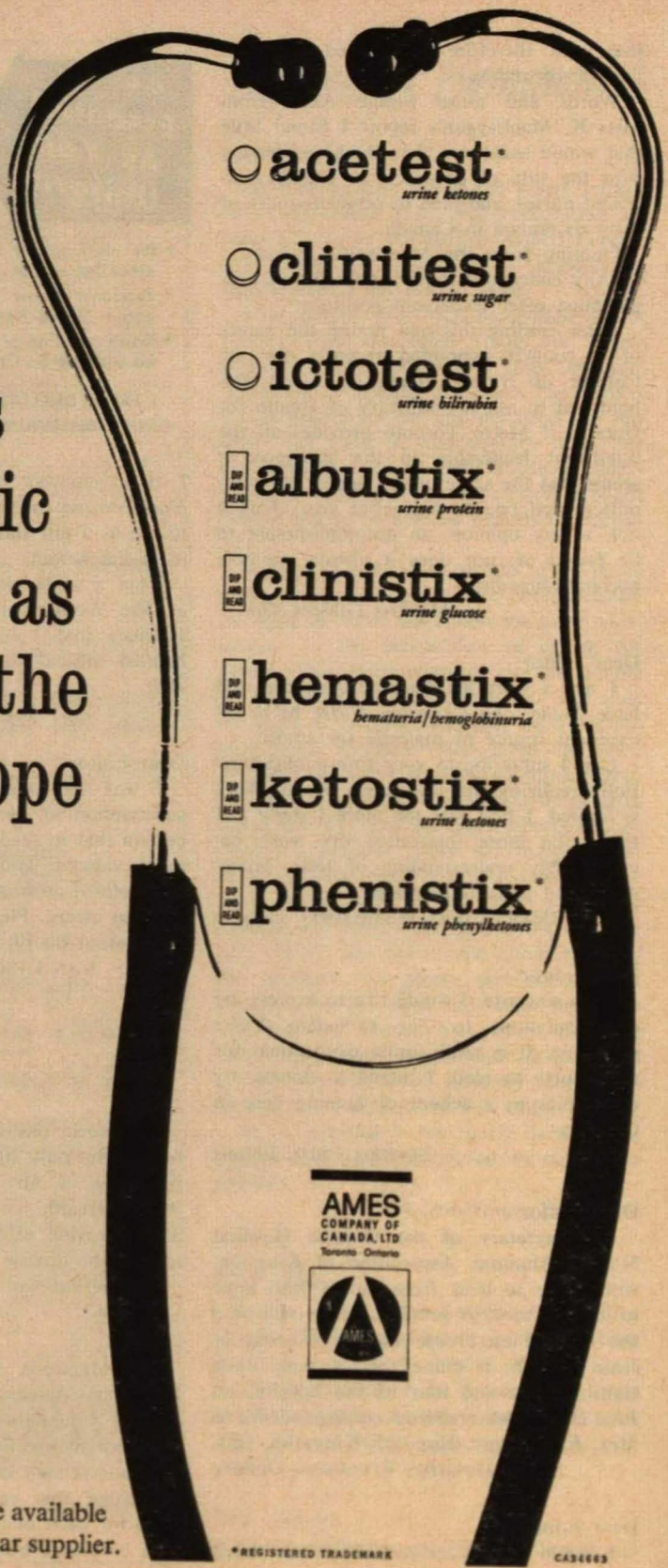

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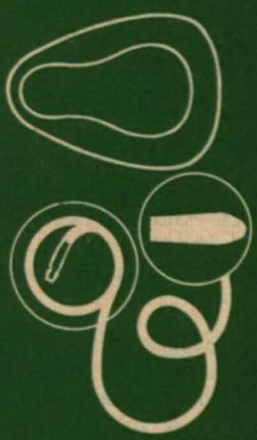

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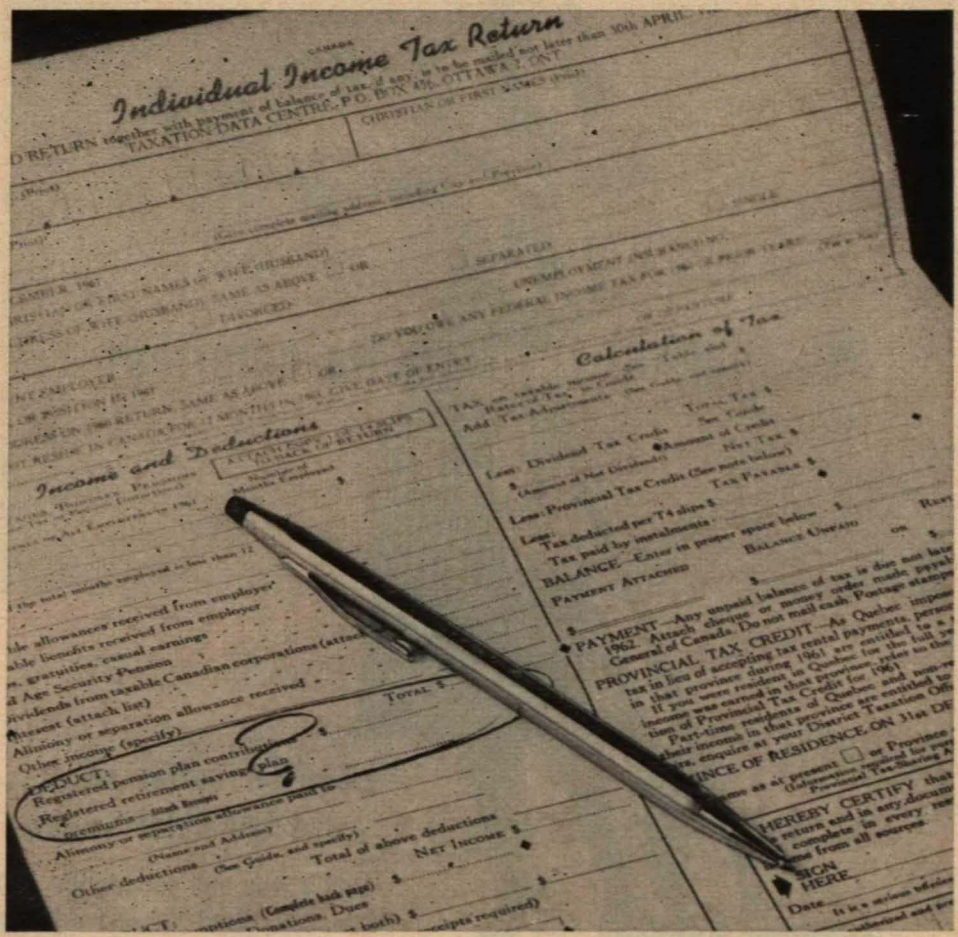

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1. Desautels, R. E., Walter, C. W., Graves, R. C. and Harrison, J. H. Technical advances in the prevention of urinary tract infection. Journal of Urology, March, 1962.

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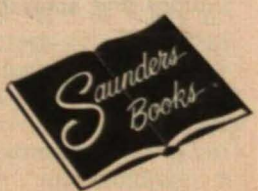

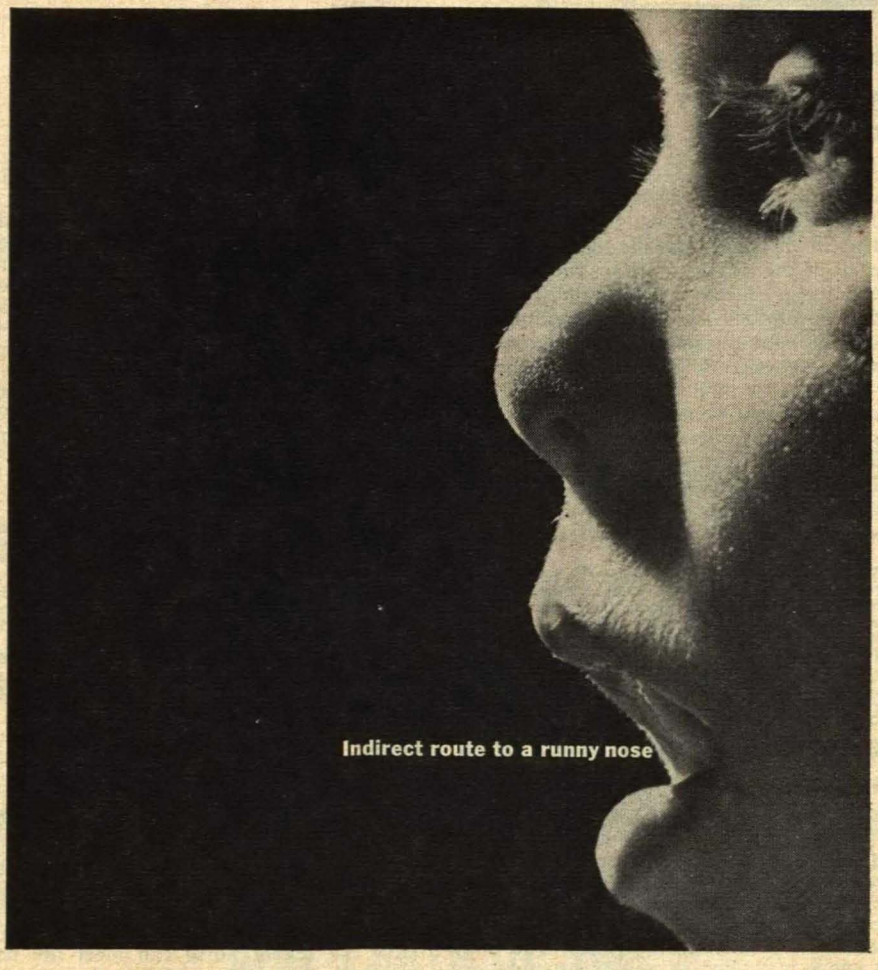

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Welcome the Patient

To many people, the hospital is a place of mystery; their conception of it is hazy, ill-defined. When they find themselves facing the necessity of hospitalization, they are restless and anxious. Anxiety functions as a sort of alarm system in the body, activating a defense mechanism that is exhibited either as some form of aggression, as a sense of being forsaken, or even in escapism. If the patient does not react against this anxiety, he becomes a prey to his symptoms. However, very little is required to relieve his uneasiness — sometimes mere contact with people who, through their composure and sympathy, help him to express his fears and regain his self-confidence.

Undeniably, the patient's first contact on his arrival in hospital results in an impression, either good or bad, that remains with him throughout the entire period of his stay. In spite of this, all too often those who are responsible for the patient's initial welcome to hospital become so preoccupied with administrative details that their response to the patient is indifferent, even rude, with subsequent effects on the patient's behavior.

The patient feels that personnel at all levels is responsible, according to respective capabilities, for his well-being and peace of mind. General good will and the sense of satisfaction that comes from a job well done should prompt a feeling of friendly sympathy for the sick whose chief desires are reassurance and understanding.

This first impression, whether it be one of cordiality, detached interest or of an unpleasant nature, originates in the admitting office. If it is really necessary, in the interests of efficient record-keeping, to have the newly-arrived patient answer an endless string of questions, would it not be possible to give some consideration as to whether or not he is in any condition to bear a long and tiring interrogation be-

fore getting settled in his room? In the case of the very ill, why would it not be possible to settle these formalities with the help of a friend or a relative? Certainly, this method would, at least, have a more personal and human touch. Tact and more tact is the first requirement.

The patient needs the feeling of being cared for and understood throughout his hospitalization. If this objective is to be reached, then re-education in attitudes within the hospital milieu becomes essential. The medical staff as well as the administrative body of an institution should be equally interested in securing consultants in public relations or in social service, or specialists in interpersonal relationships to initiate all personnel into the elementary principles of human relationships.

It may seem superfluous to remind people, dedicated to the care of others, that they should observe these principles. However, if we wish to avoid the development of thoughtless routine in daily duties, then repetition has a place.

Now that administrative authorities have somewhat less concern with the financial details of hospital operation, due to the advent of governmental plans for hospital insurance, there is no reason to neglect this essential aspect of the patient's care and recovery. Serious study, conducted outside the hospital and among patients themselves, would offer excellent opportunities to secure criticisms and suggestions directed towards improving the patient's introduction to hospital life and his later care. Regardless of the manner in which it is done, change in this area is a necessity if we wish the hospital to retain its *humanitarian* reputation.

CLAIRE BIGUÉ, B.SC.ED.INF.

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Sufferers of arthritis are warned that the drug Liefcort is dangerous. Reports of serious reactions are reaching Food and Drug authorities. These include severe uterine bleeding. Liefcort contains potent hormones including estradiol, prednisone and testosterone. Analysis showed the product contains 10 times the therapeutic dose of estradiol.

The hormones are capable of causing severe toxic effects. Prednisone has been and is being used in the treatment of arthritis but there are hazards in its use and the dosage must be carefully regulated. In some patients, the drug causes severe symptoms of toxicity. Testosterone and estradiol have never been observed to exert any beneficial effect in arthritis and may produce serious side effects.

— U.S. Dept. of Health, Education, and Welfare.

The newly formed Economic Welfare Division of the ICN, which consists of members elected from five countries, met at ICN House in July. The Director, Miss Sheila Quinn, reported that 27 national nurses associations had already nominated an *economic correspondent* to keep in touch with the Director. Information on salaries and conditions of service had been received from 26 member associations . . . The committee was encouraged to learn that a number of countries — already aware of the significant connection between satisfactory conditions of service and good nursing practice — were arranging seminars, courses or study groups for senior nurses wishing to become better informed about negotiating machinery and rights and industrial relations . . .

— *International Nursing Review,* August, 1962.

PLASTIC SURGERY

L. R. CHASMAR, F.R.C.S. (C)

Plastic surgery is the specialty that deals with the restoration of defects, congenital or acquired, and improves both function and esthetic defects.

There is a common misbelief that the word "plastic" was originally applied to a surgical specialty during the First World War. There is even mild resentment at the unfortunate choice of a label so easily confused with the products of a great modern industry. Patients have exclaimed, when an operation was suggested, "But Doctor, I didn't come for an operation, I came for plastic !" Or upon calling a parent to say that an operation had gone well for his child, he queries: "Doctor, did you use much plastic?" Such are the oddities of ignorance.

The word plastic comes from a Greek adjective which in turn is derived from the Greek verb meaning to mould or form. It was found in the Latin of the first century A.D. as plastic-us; by the time of the Renaissance, it was in common use in French (plastique) and in English.

Centuries ago, in old records concerning the Tile-makers caste in India, a description was recorded of the free transplantation of full thickness skin from the gluteal region to the nose. Prior to transplantation, the buttock was beaten producing hyperemia. The demand for this type of repair was produced by the custom of cutting off the noses of unfaithful women.

The term "plastic surgery" was established in 1838 by Edward Zeis' publication *Handbuch der Plastischen Chirurgio,* a scholarly work in which the author collected and systematized all the previously published material. In 1863 he published one of the finest of medical biographies, *The Literature on Plastic Surgery*. Although this was written some years before the introduction of free skin grafting by Reverdin, (1869), it contained no less than 2008 annotated references. Today, it refers to almost exactly the same field. Free skin grafting has been introduced and absorbed, otherwise there is little change.

Thiersch, in 1874, transplanted skin thin and free. These thin grafts did not entirely prevent contractures and the resistance to mechanical insult was meagre. In 1875, Wolfe of Edinburgh, an ophthalmologist, transplanted free full thickness grafts to the eyelids. The terms "Thiersch graft" for a thin graft and "Wolfe graft" for a full thickness graft are heard frequently.

Most of the operations done in plastic surgery today were described well over one hundred years ago. The impetus of two world wars has been largely responsible for expansion of the specialty. Sir Harold Gillies, who died in 1960, may with truth be described as the founder and father of plastic surgery in Great Britain. In 1916, he opened a small unit at Cambridge Hospital, Aldershot, for the repair of facial injuries resulting from trench warfare. Between the wars only two surgeons in England devoted themselves exclusively to plastic surgery — Gillies and Kilner. It is only since 1945, in Canada, that surgeons have confined themselves to this specialty. There are now over 50 surgeons in Canada who make their living by practising plastic surgery. The demand has not yet been met. The reason for this is two-fold — an in-

crease in the scope of the specialty, and increasing public demand for the services of a plastic surgeon.

Plastic surgery encroaches on almost every other surgical domain; how far it should extend is a matter for the individual surgeon to determine, guided by his training, inclination and conscience. A plastic surgeon's training is broad. Most of these specialists are general surgeons prior to starting plastic training. The emphasis in training is on the delicate handling of tissues. This principle is applied to whatever field the plastic surgeon enters. Burns, bed sores in paraplegics and hand injuries are three fields where the results of treatment have been disappointing. These were such disagreeable jobs for the average surgeon that he was delighted to give them up. It was not difficult to find more like the above, to endeavor to improve the results and incorporate them into the plastic fields.

Skin Grafts

1. *Free skin grafts :*
   a. epidermic (Thiersch)
   b. split thickness
   c. full thickness

A free skin graft is a portion of skin that has been completely detached from its original site and transferred to another area. The area from which the free graft is taken is known as the *donor area.* The site upon which the graft is placed is called the *recipient area.*

Epidermic grafts are cut very thin and are used when large areas must be covered as in burns. They are also used where infection is present. Their main use is to provide cover in case of skin loss. These grafts shrink, wrinkle, and do not withstand mechanical insult. They pigment and are usually darker than the surrounding normal skin.

The split or intermediate thickness graft shows the above disadvantages but in lesser degree. Both the epidermic and split thickness grafts are more certain to take. They may be applied to freshly denuded bone, to muscle, fascia, tendon, etc. The supply is usually large since the donor site heals in 10-12 days. A full thickness graft contains all the layers of the epidermis and the corium as well. These grafts shrink, wrinkle and pigment much less than thinner grafts. They are usually a good color match especially if the donor site is close to the recipient site. A full thickness graft is useful in sites which are subject to friction, such as the palm of the hand. The size of the defect determines the feasibility of using this type of graft.

2. *Composite grafts :* This is a graft of more than one tissue. The typical example is the one taken from the ear to restore the rim of the nose. It has skin on both surfaces with cartilage between.

3. *Flaps and tube pedicles :* A flap is a portion of skin and subcutaneous fat raised from the underlying tissue excepting at one site where a pedicle is formed through which the vascular supply is transmitted. The flap is transferred to a recipient site, either local or distant. Here it becomes attached and a new circulation grows into it. It is not a free graft since it has its own blood supply at all times. The flap is not severed after migration until circulation has been established in the new site. These grafts are used for defects that require a pad of fat beneath the skin.

4. *Homografts :* These are grafts taken from one individual and used upon another. Homografts never remain as permanent grafts except in the case of identical twins. They are limited to those cases in which transient relief is necessary, such as a severe burn during a critical phase.

Transplantation of Other Tissues

1. *Mucous membrane:* This is taken from inside the mouth. It can be applied to the orbit and inside the eyelids.

2. *Fat :* This may be transplanted to the peri-orbital area following trauma, or to the face of patients with hemiatrophy. It is the least successful graft and it may resorb completely in five to six months.

3. *Fascia :* This is useful to patch traumatic defects of dura : It may be transplanted to eyelids for the condition of ptosis. The donor site is the thigh.

4. *Cartilage:* Is used in the nose and for ear reconstruction. It is taken from the costal cartilages.

5. *Bone:* Cancellous bone is used and the ilium is the donor site. It is used to build up the nose, the chin, the cheekbones, and to restore the orbital floor.

6. *Tendon:* The main use for this type of graft is to the flexor aspect of the fingers. It is also used in facial paralysis to provide a sling for the paralyzed face. The tendon is obtained from the wrist or the foot.

7. *Nerve:* Occasionally a nerve graft is used at the wrist for large defects in the median nerve. The results are generally poor.

Scars and Keloids

There are four procedures which are used to diminish a scar and improve it. A scar may be narrowed, raised, lowered, or broken. Sometimes breaking a scar enables a portion of it to be turned into normal facial creases and renders it almost invisible. A broken line on the face is always much less noticeable than a long straight one.

Facial scarring that occurs after severe pustular acne can now be improved in a very practical way. Since 1949, surgical planing or sanding has become the method of choice in post-acne scarring. It cannot reduce deep pits completely but at least 50 per cent improvement can be predicted and this is quite significant.

True keloids are very discouraging to treat. Excision is followed by recurrence of a larger keloid in 50 per cent of the cases. These are better avoided surgically if at all possible. Many months of waiting results in some improvement.

Orbit

Ectropion, or eversion of the eyelid, is commonly seen in burns of the face. The eyelids receive top priority for skin grafting in burns.

Ptosis or drooping of the upper eyelid has already been mentioned with remarks on transplantation of fascia. The muscle of the upper lid may be weak. In this event the tendon of the levator is shortened, a fascia graft being unnecessary for this repair.

The Nose

The esthetic importance of the nose is great. Its position on the face is prominent and diseases and injuries are common. It is not surprising that the plastic surgeon is frequently called upon to restore or improve the nose. The operation of remodelling the nose was first perfected in 1910 by Joseph of Berlin. The method used today is almost identical. It is done through incisions concealed within the nostrils. The operation can be carried out under local or general anesthesia. The results in skilled hands are uniformly satisfactory.

Total reconstruction of the nose following cancer is occasionally necessary. By choice, a forehead flap is used and the results are excellent.

The Ear

The ear lends itself to certain types of re-positioning plastic procedures, but restoration of an entire ear is extremely difficult. Few ear reconstructions bring any great contentment to surgeon or patient. No one can duplicate exactly the human ear with living tissue.

The most common deformity of the external ear is the abnormally prominent auricle. The ear may be unusually large as well as protruding. Setting back prominent ears is a common and very satisfactory operation. It used to be more commonly done in boys; with the new hair styles of today, girls frequently request the procedure. The operation is not done before five and one-half years of age. At this age the ear has reached within one millimeter of adult size and at seven years the ear is fully grown.

Harelip and Cleft Palate

This condition has been known for many centuries. Ambroise Paré in 1575 said, "For we so commonly see lips which are cleft from the first conformation in the womb by the error of the forming faculty." It occurs once in every 670 births. When a man or woman with cleft lip marries a normal

partner the chance of their child having a cleft is two per cent.

The operation for cleft lip is done at six weeks of age when the baby is ten pounds in weight and has an adequate hemoglobin. The common operation is the "Le Mesurier," perfected and described by Dr. Le Mesurier of the Hospital for Sick Children, Toronto. The advantages are a broken scar, a full lip, and a well-formed cupid's bow at the red margin of the lip. It is important to remember that in the surgery of harelip and cleft palate, a perfect result is impossible. The operator can only do his best with the material available.

Cleft palate may occur alone. There is no genetic relationship between isolated cleft palate and cleft lip with or without cleft palate. If there is a cleft palate in the family, there is no likelihood of cleft lip occurring. The operation for cleft palate is almost uniformly successful. All the available tissue is pushed back to give maximum length to the repair. This occasionally leaves a small leak at the front where the lip repair joins the palate repair. The cleft palate is repaired at 18 months of age. Speech is good in 80 per cent.

Lips, Cheeks, Jaws

Double lip, losses of lip, and cancer of the lip, are all conditions frequently requiring plastic surgery. Because of the reconstruction required, cysts and tumors of the jaw bones are frequently treated by a plastic surgeon.

Fractures of the Facial Bones

In the past 15 years, an entity once rare has become quite common. This is the complete facial smash where all bones are broken; soft tissues are torn; spinal fluid streams from the nose and often there are associated injuries. These usually occur in head-on automobile collisions. Specialized treatment is essential at once. Often late reconstructive procedures such as bone grafts are necessary.

Hand

The atraumatic technique developed by plastic surgeons has been applied to the hand. In the acutely injured hand, prompt cover by skin is the prime consideration. Failure to achieve skin cover within eight hours could ruin forever this valuable structure. In very large centres a few surgeons devote their entire practice to hand surgery.

Hemangioma

This is the commonest growth of childhood and most occur on the head and neck. They are called strawberry moles. They are composed of small blood vessels that did not connect up properly with the rest of the circulation. They grow on their own, often at an alarming rate. They grow more rapidly than the child until nine months of age, and then slowly regress until, at five years of age, they are usually insignificant. Only the port wine stain of the face persists into adult life.

Hypospadias

In this condition the urethral aperture of the male child opens somewhere other than at the end of the penis. The opening may occur under the glands, in the shaft, on the scrotum or in the perineum. Reconstruction takes one or two operations depending on the method selected. One endeavors to complete treatment before schoolage.

Mammary Hypertrophy and Ptosis

Operation for the correction of ptosis and hypertrophy of the breast has enjoyed increasing popularity during recent years.

The hypoplastic breast requires the addition of tissue. The problem lies in the selection of the proper material. Fat grafts are likely to shrink or disappear. Fat grafts with overlying dermis or fascia are more suitable. It is a major procedure since scars are produced on the buttocks or the abdomen to secure the graft. The use of foreign material, such as plastic sponges, is very hazardous. Even the slightest infection causes prolonged drainage.

Nurse's Role

In reconstructive surgery, superlative

nursing is more than a luxury. It is a prime essential to success. Apart from maxillo-facial work, cases of cleft palate, webbed fingers, Dupuytren's contracture, hypospadias, frostbite, and burns are the daily experience of the plastic nurse. In harelip and cleft palate, the surgeon relies so fully on the nursing care that he omits all dressings. Following injury to hands, a bulky occlusive dressing is applied. With the edema that occurs in the first 24 hours following operation, a careful watch on the hand is necessary in the event that the dressing or cast should be released. Intensive nursing is required following the plastic repair of bed sores in a paraplegic. These patients are nursed prone for six weeks following surgery. They require constant vigilance at pressure points to prevent the formation of additional sores.

Accurate information as to the scope of the operation is helpful to the nurse. During the restless phase of recovery from anesthesia the patient might disturb bandages, shift a free graft, or pull on a flap, kinking it and cutting off the blood supply. There is no specialty where the work of the first-class nurse so closely approaches that of the surgeon in skill, scope, and importance.

Summary

In the first edition of *De Curtorum Chirurgia,* printed in Venice in 1597, the author, Caspare Tagliocozzi, writes:

We bring back, refashion, and restore to wholeness that feature which nature gave, but chance destroyed; not that they may charm the eye, but that they may be an advantage to the living soul.

These words, written by the man who has been referred to as the "father of plastic surgery," exemplify what a plastic surgeon endeavors to do for his patients.

In the Good Old Days

(*The Canadian Nurse* — FEBRUARY 1923)

One thing this survey (of schools of nursing) has shown is the absence of any attempt on the part of hospital boards to ask for any special qualifications in those whom they choose as members of the staff — particularly of the all-round woman they confidently expect to find in anyone who applies for the position of superintendent of the hospital and school . . . They seem to think that the mere fact of holding a diploma from any school and applying for the position is enough to guarantee that what they want will be forthcoming. One of our hopes . . . is that we may soon establish a confidential bureau for both hospital and staff nurses where we may eventually get together the right position and the right woman to fill it.

* * *

105 prominent physicians of New York City have begun a movement to force the annulment of the restrictions on prescriptions for whiskey established by the Volstead Act. It is not an anti-prohibition movement; all the physicians concerned in it are opposed to the promiscuous and wide-open sale of intoxicants. It is intended to prevent the further invasion of the professional rights of physicians.

* * *

The one outstanding error that has prevailed throughout the whole nursing system, has been the assumption that overwork and severe discipline were necessary and even desirable concomitants of nurses in training. When it began to be understood that there was a difference between the self-imposed hardships and sacrifices of the religious orders and the preparation of modern young women for a profession, it was then impossible, for economic reasons, to lift the superfluous load . . . The half century is closing without seeing definite financial relief; nursing schools still remain under the shadow of an inherited system that is only beginning to be ameliorated . . . To go on as in the past, almost entirely under the apprenticeship system, is impossible. The needs of the hospitals and the educational requirements of the students must be harmonized in those institutions that wish a high grade of nursing service.

— *History of the Massachusetts General Hospital Training School.*

Nursing with Indian and Northern Health Services

ALICE K. SMITH

An introduction to a series of articles by persons engaged in this work

Functions

Indian and Northern Health Services is a division of the Medical Services' Directorate, Department of National Health and Welfare. The purpose of the division is to assist the Indian and Eskimo people of Canada to reach and maintain health and living standards comparable with those of other citizens. Its broad functions are to provide or arrange for essential medical treatment for any Eskimo or registered Indian who requires assistance in obtaining care; to try to insure that an appropriate public health program covers every reserve and native community; to act in the Northern Territories, as a health department for the entire population including the non-native residents.

Many Canadian Indian and Eskimo people live in outlying areas where it is difficult to provide adequate health care. In view of this and the lack of financial resources on the part of the people, the Federal Government has made funds available to Indian and Northern Health Services to provide basic public health and treatment services either within their own resources or through arrangements with other appropriate health agencies. This is in fulfilment of a moral obligation. Contrary to popular belief there is no law on the statutes that makes this program obligatory. However, the fact that the obligation is moral rather than statutory only serves to make it seem more binding. The provision of "medicine chests" was mentioned in two of the numerous treaties made with the Indian people. It could be said that Indian and Northern Health Services, with a budget which now amounts to $25,000,000 represents these "medicine chests."

Organization

The staff totals roughly 2,500 and includes more than 1,000 nursing personnel, two-thirds of whom are registered public health and hospital nurses, and one-third auxiliary nursing personnel. There are 114 full-time medical officers, 26 full-time dentists, 36 administrative officers and a wide variety of specialists and supporting technical, secretarial and clerical workers. Approximately 15 per cent of the employees are Indian and Eskimo people, some of whom are nurses.

There are 18 hospitals with a total of 2,100 beds and bassinets. Eight of these hospitals admit both tuberculous and general patients and the remaining 10 are general hospitals. They are located in areas extending from Frobisher Bay, Moose Factory and Ohs-

weken in the east, to Whitehorse, Prince Rupert and Nanaimo in the west.

Outpost nursing stations number 35 and have a total of 175 beds. They are located both in the northern parts of several provinces and in the Territories where medical care is not readily available. The stations are staffed by two or three registered nurses or registered nurses and auxiliary nursing personnel, a caretaker and a housemaid. It is essential that one of the nurses should be highly qualified in obstetrical nursing or midwifery. Maternity and emergency patients are admitted to the stations; home nursing care is carried out and taught in the homes; a community public health nursing program is conducted with participation by the people. One of the articles in this series will be devoted to describing the work and facilities of an outpost nursing station.

Generalized public health nursing programs, with emphasis on home visiting, are conducted from 80 health centres some of which are in towns and others in semi-remote areas. A further 31 clinics staffed by full-time medical and nursing personnel provide combined public health and treatment services in their respective communities.

Responsibilities

Indian and Northern Health Services is responsible for the administration of health and treatment services only. All other services provided for the Indian and Eskimo people are the responsibility of the Indian Affairs Branch of the Department of Citizenship and Immigration and the Northern Administration Branch of the Department of Northern Affairs and National Resources.

Decentralization of administrative responsibilities is essential in an organization as widely spread and as complex as Indian and Northern Health Services. Canada, including the Territories, is divided into five regions and each region is divided into zones. The boundaries of the regions and zones are determined by communication facilities, distribution of the Indian and Eskimo population, geographical peculiarities such as mountain ranges, and other factors. The regional head offices are in Vancouver, Edmonton, Regina, Winnipeg and Ottawa. Each region and zone has its own administrative team headed by a regional or zone medical superintendent.

Details are being worked out at the present time to bring into full effect the amalgamation of all direct health and medical care services within the Department of National Health and Welfare. The name of the new directorate is Medical Services. The Director is Dr. P. E. Moore. The services involved in the amalgamation are: Civil Aviation Medicine; Civil Service Health; Quarantine, Immigration Medical and Sick Mariners; and Indian and Northern Health.

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HEALTH CARE FOR WEST COAST INDIANS

GRACE HARRIS

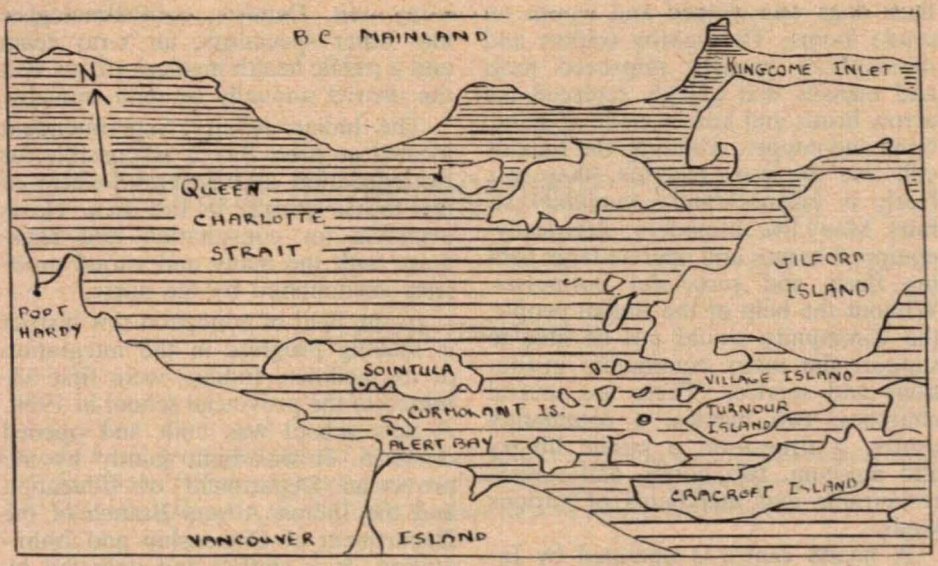
This article deals with the health care of the Indian people in British Columbia.

About 40 per cent of the 40,000 Indians in British Columbia live on the coast, on islands, inlets and rivers. Many others are located further inland in the valleys of the Stikine, Nass, Skeena, Bulkley, Fraser, Thompson, and Columbia Rivers.

The communities vary in size. Some consist of three or four families while in others there are more than 1,200 people. Great variations are also found in the cultural backgrounds, languages, resources, employment opportunities, and degree of acculturation. Most of the Indian people in British Columbia have officially adopted Anglo-Saxon family and Christian names. Colorful Indian names have been retained in some of the 200 band names, such as Gitlakdamix, Kitsegukla, Kitamaat, Mamalillikulla, and Yakweakwioose — as well as in many places with names of non-Indian communities. Most of the Indians in British Columbia are bilingual, speaking their native language as well as English.

Contacts with Europeans (explorers, missionaries and traders) began late in the 18th century and have increased rapidly in the past 50 to 100 years. This rapid transition from a primitive culture to the atomic age has produced great stress and strain on individuals and communities. There is a need for understanding and guidance to assist these people to reach and maintain standards of health and living comparable with that of the remainder of the Canadian population. Indian Health Services is one of the agencies designed for this purpose.

The provincial Department of Health in British Columbia cooperates with this agency and assists in many ways. Specialized services, such as Vital Statistics, the Registry for Handicapped Children, V.D. Control, and the Public Health Laboratory, are made available to Indian Health personnel. Voluntary agencies, such as the Cancer Clinic, the Rehabilitation Centre, and the Canadian National Institute for the Blind, also include the care



of the Indians in their plans. The British Columbia Hospital Insurance Service, covering care in all general hospitals in the province, is available to Indian people on the same basis as non-Indians. The Indians pay the general sales tax that supports the hospital services.

Public health nurses employed by the provincial Department of Health and the Metropolitan Health Committee of Greater Vancouver provide local public health nursing services to approximately 6,000 Indians on reserves. Twenty nurses, most of whom are qualified in public health, are employed by Indian Health Services in 17 health centres and clinics throughout the province. These nurses offer a generalized nursing program to the remaining population of roughly 34,000. A total of 110 registered nurses and 90 nursing assistants and nursing orderlies are employed in the three departmental tuberculosis hospitals at Sardis, Prince Rupert and Nanaimo. The work of the hospital nursing staff is similar to that in any hospital. The public health field nurse can look forward to a great variety of professional experiences as well as different climates, scenery and community life. There is really no typical district, but the one described below is fairly comparable to other districts on the Pacific Coast.

Alert Bay

This district is situated 180 miles north of Vancouver on Cormorant Island just off, and within sight of, the east coast of Vancouver Island. Both Cormorant Island and Alert Bay were named after British warships that visited the area in 1846 and 1858, respectively. The climate is mild and moist, similar to that found in other parts of the southern British Columbia coastal area. There is daily plane and mail service to and from Vancouver, with several freight and passenger boats calling weekly. There are local and long-distance telephone and telegraph connections as well.

The local Indian people are descendants of the Kwakiutl nation. The original population of 3,500 was greatly reduced by a smallpox epidemic in 1870. In recent years the numbers have been increasing by four to five per cent yearly, and the present population of registered Indians in this agency is 2,276. One-quarter of these live at Alert Bay. The remainder live in 15 distinct villages on the nearby islands and inlets.

Historically, the Kwakiutl people were a wealthy and independent nation. The sea provided an abundance of food, supplemented by game, berries and roots. The forest provided a ready supply of material for house and boat building, food containers, and the totem poles and masks for which these people were famous. Clothing was made from tree bark, as were mats and baskets; the long, fine, white hair of

their dogs was clipped and woven on crude looms. The nearby traders and missionaries brought improved tools and utensils that quickly replaced the arrow heads and knives made of stone, bone and copper. Although the Indians still live on their reserves, they mix freely in business and community affairs. Many live in modern, electrically-equipped homes and operate large fishing fleets and successful businesses. Without the help of the Indian people, the community would not be able to support the many community institutions and services. There are several churches, two movies, a community centre, a drugstore, a public library and museum, two hotels, and several restaurants and merchants of various kinds.

A health centre is operated by Indian Health Services at Alert Bay. The building has clinic and office space on the main floor with living accommodation above. The staff consists of a public health nurse and a part-time clerical worker. The local people attend clinics in the centre. Child health conferences, immunization clinics, school health clinics and group health education classes are held regularly by the public health nurse. Similar clinics are held by eight smaller communities that the nurse visits on a monthly basis. The nurse travels to these villages by boat or by small float planes. The maternal and child health program is given preferential attention with specialized services integrated for tuberculosis control, venereal disease control and mental health.

There are two physicians and a small general hospital at Alert Bay. A mission boat, usually with a doctor aboard, visits the smaller communities from time to time.

The first hospital was opened at Alert Bay in 1909. When this building was destroyed by fire in 1923, a larger building was provided and the Indian people donated money to purchase an x-ray unit. Dentists, ophthalmologists and other specialists, an x-ray team and a public health medical officer visit the district annually or semi-annually.

The Indian Affairs' Superintendent located at Alert Bay is responsible for the education and general welfare of the Indian people in the area. He is available for consultation and assistance with the many and varied problems encountered by the nurse.

In the field of education this district is making progress in the integration of its facilities. Indians were first admitted to the provincial school in 1939. A new school was built and opened in 1955. It was built jointly by the provincial Department of Education and the Indian Affairs Branch of the Department of Citizenship and Immigration. It is staffed and operated by the province of British Columbia. In addition to the larger schools located at Alert Bay, seven one-or two-room Indian day schools are located at Quatsino, Tacush (not shown on map), Kingcome Inlet, Village, Turnour, Gilford, and New Vancouver Islands. The schools become the headquarters of the public health nurse when she visits these small villages.

The teachers in both Indian and provincial schools work in close co-operation with the nurse and the people in the community. Organized groups, such as homemakers' clubs, church groups, health committees or band councils, offer opportunities for group discussion and the development of community leaders.

Alert Bay is a rapidly changing community. There are many Indian people who are quite capable of keeping abreast of the tide without much assistance. Others, as shown by a high infant mortality rate, need much understanding and guidance. For the public health nurse in this area, there is a great challenge and an opportunity for maximum job satisfaction.

A little philosophy inclineth man's mind to atheism; but *depth* in philosophy bringeth men's minds about to religion.

— FRANCIS BACON

Demand not that events should happen as you wish; but wish them to happen as they do happen, and you will go on well.

— EPICTETUS

Training of Management Personnel

J.-PIERRE HOGUE, PH.D.

Certain basic principles should be used as guides to action by those in managerial positions. When promoting a member of staff to fill a managerial role, the administrator should take certain factors into consideration.

This article studies four essential features:

1. The need to train personnel for managerial positions;
2. The need to develop personnel management techniques in hospitals;
3. Some personnel management principles;
4. Introduction to various training methods and techniques.

Training Need

Department heads, supervisors, and all those in charge of subordinates in hospitals represent, for their employees,* the management of the institution. These persons are key-figures in the hospital. They direct and supervise their employees; provide a budget; review expenditures and purchases; select and train capable subordinates; coordinate the activities of the organization in order to obtain maximum performance from all employees, while treating them fairly and satisfactorily. Within the hospital framework, a person in charge of other employees must fulfil her own responsibilities to the utmost. The top administrators should select their supervisors and department heads with special care. The efficiency of these people, in turn, will depend upon how well they are prepared to guide and direct others.

Very few hospitals have succeeded in developing training programs for management personnel even though these employees are key-figures. Warm and constructive human relationships between staff members depend upon the selection and adequate training of the personnel in managerial positions.

Any management training program must set up objectives:

1. Employees' satisfaction;
2. cooperation among the members of a team or group;
3. promotion of justice;
4. improved work efficiency.

While these objectives directly concern the hospital, they may also be related to any industry. The following objectives are specific for the hospital field:

1. To improve the quality of patient care;
2. to lessen nursing service costs;
3. to create a friendly environment and establish warm relationships with the patient.

If hospital employees show mutual understanding, the whole institution will function more efficiently. For instance, if the kitchen aides, the dietitians and their director work together harmoniously, the patient receives better food service which, in turn, helps to improve his relationship with his

* The term "employee" includes all levels of staff: assistants, technicians, supervisors, etc.

nurse. In other words, appetizing food will incline the patient to comply with the requests made upon him by nurses or other hospital staff. Therefore, the adequate training of management employees is of vital importance since, they are responsible for the promotion of good interpersonal relationships as well as ensuring satisfactory work performance. Many techniques contribute to the realization of such training. The results will not be successful unless personnel management people show leadership ability.

The growth of hospital services as well as the progress achieved by medical science have increased the complexity of hospital management. This state of affairs will continue as long as administration keeps pace with the scientific and social progress of our civilization. Patient care requires increased services from all administrative personnel. Well-balanced management of a hospital — the working field of medicine and the stage of the eternal struggle between life and death — depends upon a constructive attitude and a sound organization that will integrate all services, coordinate all efforts and promote the main functions of the institution, while fostering a team spirit.

An administrator once noted that one of the most regretful deficiencies of our times was not the shortage of employees, but rather the incompetence of a management unable to guide its staff intelligently. This remark applies to every service in the hospital. The employee turn-over and adaptation to new tasks constitute acute problems. Since the most complex problem that faces hospital management is human relations, the recruitment of qualified leaders is essential.

During a conference held for personnel managers, department heads and hospital administrators, the following conclusion was reached: The supervisor or anyone in charge of personnel represents authority for her subordinates. In other words, she interprets the policy, aim and objectives of the hospital. The words she utters, the measures she takes in accordance with the work that was accomplished in the department, reflect the very attitude of management. The administrators who attended the meeting thought it advisable that their department heads should be aware of their duties and realize that they are largely responsible for the efficiency of their own hospital. Since department heads represent management, they must influence their employees' behavior toward the institution. If they misunderstand their own positions, their attitude toward the employees will also be affected. The quality of service will depend upon their leadership ability.

The education of a good leader is of vital importance. The principles and methods that constitute this training program generally lack perspective in human relations. Too many department heads receive their promotion without being given required training. How, then, can they be expected to lead their employees?

Importance of Developing Techniques

The training of management personnel represents considerable expense. It would be preposterous to install such a system in the hospital simply because it meets with public approval at the moment. Before developing such a program, every administrator and department head should be able to group, systematically and logically, all of the activities within the hospital. The administrator will be requested to answer two main questions. First, "Do I have to introduce a management and staff training program?" Then, "What advantages can I derive from such a program?"

About 300 hospital administrators, personnel managers, department heads and assistant administrators took part in debates centred on staff training. Solutions submitted by this group may be found in a manual published by the American Hospital Association.** The administrators were asked to list the duties and responsibilities assumed by anyone in charge of employees. Although the results were obtained from non-extensive studies, 50 answers emphasized the duties and responsibilities assumed by those in charge of per-

** Conference, Technics on Supervision and Supervisors' Work, Functions, Performance and Training. Multilithed notes, Conference Work-Shop.

sonnel management. This seems to demonstrate the importance of the position held by the latter.

If administrators are burdened with too many tasks they will not be able to accomplish anything. They need the help of well-trained assistants to whom they can assign the management of staff. This will enable each individual to improve her work performance. It will permit the administrators to give better assistance to their subordinates who, in turn, will reflect a marked improvement in their attitude. The manual lists and studies some unfortunate situations caused by inadequate training of those in charge of employees. The importance of management training is made obvious.

We have studied briefly the necessity and importance of developing personnel management techniques in hospitals. However trivial the next statement may seem, it remains of basic interest. Those responsible for personnel management have to create relationships with all hospital staff. Their work brings them in contact with employees, doctors, other members of professional staff and administration. They must obtain the cooperation of all. Moreover, they have to solve problems, direct workers, handle grievances, etc. In their work situation, *human relations* are of extreme importance. They must be taught the basic principles of personnel management.

Principles of Management

1. Personnel management should belong to the higher level of organization. The upper organizational structure must be defined clearly and accurately.

2. Those in charge of employees should be able to relate their administrative duties to their leadership responsibilities.

3. In order to maintain a highly efficient personnel management, the various activities of the organization should be stated clearly and logically.

4. A person responsible for other employees should demonstrate great scientific knowledge as well as objectivity; his behavior should be well-balanced.

5. All employees should cooperate in a democratic fashion.

6. There should be opportunity for communication downward and upward in the organizational structure. This is called the principle of communication.

These principles must be applied by those in charge of employees. They are the key to constructive results. It would be useful to mention the results of another study in order to evaluate these statements with greater accuracy.

A research project on organization was held in the University of Southern California.† The results indicated that certain factors must be taken into account, when attempting to solve personnel management problems:

a. Group factors
b. Counselling problems
c. Principles or relationships between subordinates and superiors
d. Organizational structure
e. Decision-making
f. Control and coordination.

Group factors

We must recognize and accept the existence of groups within the various departments of the hospital. Before making any decision, the person in charge of employees should consider the group rather than the individual. The study mentions this factor. Spontaneous groups where employees feel free to evolve should be permitted to develop. In fact, these explanations express the principle of hierarchy.

Counselling

Best results are obtained by skilful counsellors, in other words, by those who promote valuable relationships between themselves and their subordinates. It is recognized that the non-directive method is the best technique of approach. This consists of an encounter during which the superior listens to rather than talks to her subordinate. This statement constitutes the principle of availability.

Relationship between superior and subordinate

The USC study established the fact that everyone in charge of employees performs her task more efficiently if:

She does not over-criticize;
she has confidence in her superior(s);

† Herzberg, F. et al., *Job Attitudes: Review of Research and Opinion*, Pittsburgh, Psychological Services of Pittsburgh, 1957, pp. 175-178.

she gets along well with her superior(s);
she can communicate with her employees;
she is able to maintain firm discipline;
she does not let her security within the organization preoccupy her.

This is the essence of the "staff and line" principles.

Organizational structure

The person in charge of employees does not fulfil her position efficiently unless the whole organization:

Demonstrates adequate authority;
gives her the opportunity to establish and maintain some independence;
offers positive and specific methods and policies;
presents a definite sequence of command.

This statement expresses the unity of command principle.

Decision-making potentialities

Efficient supervisors as well as all those who direct employees successfully are steadfast. They show decision-making potentialities without being impulsive. This is a factor that must be considered in the delegation of authority.

Control and coordination

Tensions may prevail among the groups that constitute an organization. For example, in the newspaper business, strain exists between the editorial and publicity teams. In the hospital, relationships between the medical staff and the administrators, the nursing service and the accounting department may sometimes be tense. The introduction of a competitive spirit within each group promotes its harmonious functioning. Furthermore, every service must learn to recognize its own control rights. These statements express the principles of control and coordination. If they are followed, no department will be isolated from the others.

Training Techniques

The evaluation of training methods and techniques constitutes a complex study. There are innumerable techniques that aim to improve staff education. Three of these are mentioned below.

1. A *standard manual* containing a description of the tasks and responsibilities connected with a position, should be of great help to employees. Before accepting a task, the individual will know exactly what to expect. The importance of the described position as well as its situation within the service and the whole hospital can be explained. Even if the employee is concerned simply with a routine task, she will be able to evaluate her position and complete her perspective of things. She will also acquire a sense of her own importance; she will realize that her position is part of a whole.

2. A *blackboard* occupying a conspicuous place in the department is also extremely useful. It allows for the recording of operating costs (for instance, breakage of dishes in the department of dietetics), absences, delays, etc. A comparison should always be established with previous years or months. Although no name is mentioned, everyone may realize the extent of the progress realized and take note of the points needing improvement. Such a method promotes a sense of responsibility within each group.

3. We should not forget the method of *meetings*. Dates of the conferences should not be established according to the whims or availability of the department head. Here again, valuable communication should take place. It should be obvious to the employee that no discussion will be aimed against her.

Conclusion

The efficiency of the techniques mentioned will depend upon the availability of the superior. (Superior means the person in charge of employees). The value of these methods is basically connected with the leader's own value. She must not forget a main feature: Since she deals with *human beings*, she must fulfil *human-centred* duties. If she remembers the existence of words such as *communication* and *availability*, she will help solve most of the problems that her staff submits to her. It only remains for her to learn how to apply the basic principles of administration.

Every great and original writer, in proportion as he is great and original, must himself create the taste by which he is to be relished. — WILLIAM WORDSWORTH

THE NURSE-ROLE:

An Instrumental and/or Expressive Function?

JAMES K. SKIPPER, JR. *and* RAYMOND E. SAKUMOTO

Recognition of the difficulty of formulating questions which do not suggest a particular answer is a pre-requisite to the appreciation of an opinion study.

Two Schools of Thought

The sociological literature provides two separate, but overlapping, formulations of the nurse's role in a doctor-nurse-patient relationship. The first maintains that the nurse's role is concerned with the instrumental function of "getting the patient well."[1]

> . . . the pattern of expectations constituting the nursing role is characterized by disinterest, functional specificity, affective neutrality, universalism, and performance-oriented achievement.[2]

According to this school of thought, the individual in the hospital is regarded by nurse and doctor alike as simply a *patient,* a *case* to be cured, but not as a *person.* It is not within the nurse's role to become involved with the patient emotionally or socially beyond functional necessity. It is postulated, therefore, that the idea of nurses marrying their patients will be received with contempt, disgust, and disapproval by nurses. Also, when a patient is beyond the possibility of recovery, since the end of the system is thwarted,

> . . . the operation of the patterned variables may be twisted so as to render the helpless patient the victim of callousness and aggressive impulses on the part of doctors and nurses.[3]

The other theoretical formulation of the nurse's role recognizes that nurses contribute to the solution of the system's external problem of "getting the patient well," but contends that this is not their primary task.[4] It is the doctor's role that is viewed in terms of the instrumental function of giving the patient the technical assistance he needs to regain his health. Yet, these instrumental activities create high levels of emotional tension in the patient which threaten their effectiveness. The nurse's role in this three-way relationship is expressive,* one of system integration, rather than mainly instrumental.[5] By her explanations, willingness to listen and understand, by keeping the physical surroundings pleasant, and generally providing comforting care, the nurse functions not so much to cure the patient but to maintain the motivational balance so necessary while the patient is undergoing the technical procedure required to return him to a healthy state.[6] Therefore, the nurse must treat the patient as a *person*

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* Actions which are directly related to achieving the external goal are called instrumental, while those related to maintaining equilibrium are called expressive. (See Reference No. 5)

whom she cares about, rather than just some physical object.

The Study

Purpose

The above discussion makes it obvious that sociologists, working independently, have come to quite different conclusions regarding the nurse's role. Neither of the two schools of thought has extensive empirical evidence to support its claims.† The primary purpose of this study is to investigate these conflicting notions in a doctor-nurse-patient social system.§

Assumption

It can hardly be argued that a nurse does not perform any instrumental functions. The administration of medications and the constant observation of the patient's condition are enough to invalidate this line of reasoning. A glance at the many technical medical courses included in the nursing school curriculum[7] provides a basis for assuming that nurses are expected to do more than make the patient comfortable during his stay in hospital. The assumption is made, then, that the nurse is expected to engage in instrumental functions.

Hypothesis

Is she also expected to engage in expressive functions, and, if so, to what extent? How far may a nurse stray from strictly instrumental activities and still be within the expectations of her role as a nurse? The hypothesis to be investigated is: Although the nurse's role provides for her to engage in instrumental functions || it also permits her to engage in many expressive functions.[8]

Method

The instrument employed in the project was a questionnaire which included items dealing with:

a. pertinent background information;

b. expressive orientations in role conceptions;

c. nurse-patient marriages and other personalized relationships; and

d. the handling of terminal patients.**

It was answered by 239 student and graduate nurses in a large metropolitan hospital.†† The 30 items which made up the questionnaire theoretically defined the extreme limits of a hypothetical continuum. This extended from complete exclusion of expressive functions to the recognition of a priority of these over instrumental functions. The respondents were asked to indicate whether they "agreed," were "indifferent," or "disagreed" with each item.

Results

Table I presents evidence that nurses believe that their role includes more

† Thorner's ideas, in his own words, were obtained ". . . as a participant observer-patient in large private hospitals. Simpson, following Thorner, bases her notations on a case study of student nurses. She presents little quantified data to support her claims. The Martin-Johnson study is based on an empirical analysis, but no quantified data is presented.

§ For purposes of this study, "role" refers to the rules, norms and expectations which are a function of the status "nurse," and prescribe how any person occupying that status ought to behave. "Expectations" operationally refer to nurses' self-report of how they ought to behave.

|| This implies that nurses are, to a degree, both "task specialists" and "social specialists." Bales, (see Reference No.8), in a series of small group experiments, has found that these two factors are usually uncorrelated, that is, the degree of participation in instrumental activities is not predictive of the degree of participation in expressive activities.

** Other hypotheses which were tested in this study and will be reported at another time include: the extent of the adaptation of the nurse's role while she is a student; the effect of religious background; and the effect of altruistic motives for entering the nursing profession on the development of expressive role orientations.

†† The limited time and resources available to the researchers made use of a random sample prohibitive. The population used was composed of 59 registered nurses and 180 student nurses. Since no significant differences were found between the two groups the results were pooled for the purposes of this report.

Table I

Summary of Responses to Four Items Indicating an Expressive Component in the Nurse-Role

Item	*Agree*	*Indifferent*	*Disagree*
In her own mind a nurse should think of patients as "cases" and not as persons.	3.8%	.8%	95.4%
In her actions a nurse should treat her patients as "cases" and not as persons.	2.9%	2.1%	95.0%
A nurse should keep in mind that a patient is first and foremost a person who needs sympathy and understanding, and not one who is simply ill physically.	91.6%	7.6%	.8%
A nurse should only be interested in the recovery of her patients.	8.8%	1.2%	90.0%

than the performance of instrumental tasks. 91.6% of the 239 nurses agreed with the item: "A nurse should keep in mind that a patient is first and foremost a person who needs sympathy and understanding, and not one who is simply ill physically." 90% disagreed with the statement that: "A nurse should *only* be interested in the recovery of her patients." 95.4% of the respondents disagreed with the statement: "In her *own mind* a nurse should think of her patients as cases and not as persons." On a related item: "In her *actions* a nurse should treat her patients as 'cases' and not as persons," the response was 95% disagreement.

The "instrumental" school maintains that terminal patients, that is, "patients beyond the possibility of recovery," should receive less attention than those with the possibility of recovery, because the primary objective (the instrumental function) is hopelessly frustrated in these instances. Table II summarizes the data relating to three items on treatment of terminal patients. It is highly significant, in refuting a strictly instrumental approach to the nurse's role, that *none* of the 239 respondents thought that the nurses *should give less attention* to these patients. The facts that 39.2% thought that doctors give less attention to patients in this category suggests that an instrumental orientation may be more applicable to doctors' behavior than to nurses'.

The nurses indicated they felt that " . . . listening to the patients and discussing their personal problems with them" were functions within the realm of their role. More than 86% disagreed with the item that nurses should not spend much time in these activities. In fact, almost three out of four (74.1%) reported that they are encouraged by their supervisors "to listen to the patients and discuss their personal problems with them." An attempt was made to assess to what degree the nurses believed they ought to become personally involved with their patients. Over two out of three (68.2%) felt that "a nurse should be personally interested in the problems of her patient." Establishing lasting friendships and associations with patients was considered quite permissible by 62.8%. However, when the respondents were asked to indicate how they felt about the statement: "I disapprove of close personal relationships between nurse and patient," only 46.4% agreed.§§ 21.8% disagreed with the statement:

Table II

Treatment that should be and is given to terminal patients.

	Nurses Should Give	*Nurses Give*	*Doctors Give*
Less Attention	——	9.9%	39.2%
Same Attention	51.9%	37.0%	36.5%
More Attention	47.3%	50.8%	22.7%
No Response	.8%	2.3%	1.6%

"A nurse should not become emotionally involved in the recovery of her patient." The progressive decrease in these percentages (68.2, 62.8, 46.4, 21.8) seems to indicate that warm and cordial nurse-patient associations are appropriate and even perhaps essential, while the propriety or need for nurse-patient interactions which may be defined as "close, or personal" is questionable.

The subject of marriage between nurse and patient is more complicated. Almost 70% of the responses were at variance with the "norm" that: "Nurses *should not* be allowed to marry their patients." These responses indicated that marriage is not one of those "close personal relationships" which nurses view with suspicion. A reasonable interpretation of this apparent inconsistency with common sense notions of social distance was suggested by several student nurses. Marriages between nurse and patient, they explained, almost always take place *after* the patient has been released from the hospital.

To ascertain whether the nurses recognized a priority of expressive functions over instrumental, or vice versa it was asked if "A good nurse attends to the bodily needs of the patient before attending to his personal and emotional needs:" 28% agreed, 58% disagreed, and the remaining 14% were indifferent. The data on this item show a preference, but not a substantial one, for expressive functions over instrumental ones.

Conclusion

The results of this study show that nurses view their role as containing much more than strict adherence to instrumental tasks. They see it as requiring them to participate in a variety of expressive tasks. On the other hand, the evidence is negligible to support the theory that nurses feel they are expected to engage entirely or primarily within the realm of the expressive function. Thus it may be concluded that neither of the aforementioned schools is justified in placing primary emphasis on one function, to the relative or total exclusion of the other.

It might be useful to view the nurse's role as a combination of both instrumental and expressive functions. The nurses seemed to consider the expressive function to be the more important, since no respondent felt that nurses should give terminal patients less attention and a majority indicated that nurses should not attend the bodily needs of patients before their personal and emotional needs.

Limitations

Roles are usually defined in terms of collective expectations; this report has taken into consideration only nurses' expectations of the nurse-role. Although one may argue that nurses' expectations may be, in no slight degree, reflections of the expectations of the other members of the system,[9] a thorough exploration of doctors' and patients' expectations of nurses is needed before valid conclusions may be drawn. Before either component of the nurse's role can be adequately assessed in relation to the total needs of the system, an investigation of the doctor and patient roles within the system should be made.

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2. Thorner, *op. cit.*, p. 532.

3. *Ibid.*, p. 536.

4. Johnson, M. and Martin, H.: "A Sociological Analysis of the Nurse Role," *Amer. J. Nurs.*, 58:373.

5. Bales, R.: The Equilibrium Problem in Small Groups, *Working Papers in the Theory of Action*, Parsons, Bales and Shils, eds. Glencoe, Illinois: The Free Press, 1953, p. 111.

6. Johnson and Martin, *op. cit.*, p. 375. The Martin-Johnson study is evidently based on an empirical analysis, but no attempt is made to present any quantified data.

§§ It can be argued that this response is a function of a "loaded" question. "Close personal relationships" is rather ambiguous. However, on the basis of data not reported here, it appears that a common meaning is present.

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DIABETES IN CHILDHOOD

MIMI M. BELMONTE, M.D., C.M., F.R.C.P. (C)

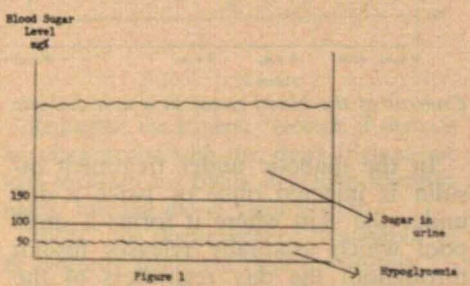
Acceptance and self-discipline : the diabetic child's key to a good life.

Diabetes is common in middle age (2% of the population) but rare in children under fifteen where it accounts for only 5% of the total diabetic population. It is almost unheard of in infancy — I am aware of only one case under six months reported in the literature. Peak incidence of diabetes in childhood occurs at periods of rapid growth — around two, between seven and eight, and at puberty.

The onset of the disease is clearly marked by the rapid appearance of classical signs and symptoms in a previously healthy child. The manifestations of the disease reflect the physiological disturbances resulting from lack of insulin. Without sufficient insulin the body is unable to make full use of the food it consumes with the result that the child's growth is arrested, he loses weight and lacks energy. Furthermore unused sugar piles up in the blood and overflows into the urine (see *Fig.* I).

The high blood sugar has a diuretic effect which increases the daily output of urine, producing polyuria of increasing severity. Thus a child who was trained may suddenly start wetting the bed at night or if older he may get up two or three times during the night to void. The excessive urination robs the body of its water and causes intense thirst. The child is therefore frequently visiting the bathroom — a symptom which alarms the parents and leads them to the doctor. On the other hand they may be less observant in which case the child will regress in a downward course leading to diabetic coma. He becomes progressively more dehydrated and acidosis develops leading to the typical rapid, deep and pauseless breathing described by Kussmaul. A sweet odor of slightly spoilt fruit appears on the breath indicating the presence of acetone. Abdominal pain with rigidity, vomiting and deepening coma ensue. At this point he has become a severely ill patient in urgent need of treatment in hospital.

The sequence of events leading to diabetic coma occurs rapidly in a child.



High blood sugar causes sugar to appear in the urine — a low blood sugar results in hypoglycemia.

A three to six week history is the rule. Emergency treatment with insulin and intravenous fluids will correct the situation and return the patient to health, but this represents only a small part of what remains to be done. Diabetes is a chronic disease which present forms of treatment do not cure. Only with constant use of insulin, adherance to a diet and careful monitoring of control through frequent testing of the urine can the diabetic child remain healthy.

It becomes necessary for the patient and his parents to learn as much as possible about the disease and its treatment. More important, they must learn to accept the fact that the child has a chronic ailment which will impose certain restrictions on the patient and his family. These need not be onerous if there is good understanding of the problem. Moral support from the attending physician, nurse, dietitian and social worker will help them to accept the demands of the disease and learn to recognize them for what they are — a key to life rather than a series of unpleasant rules. Let us not forget that prior to the discovery of insulin diabetes carried a death sentence in childhood.

One of the actions of insulin is to lower the blood sugar. In the normal state, insulin is released by the pancreas on demand each time the blood sugar rises (see *Fig. 2).*

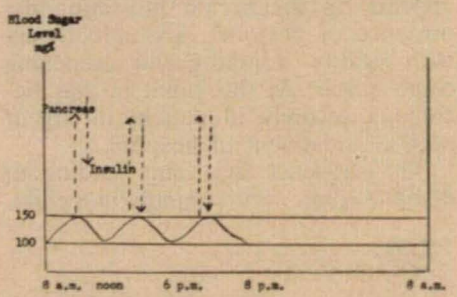
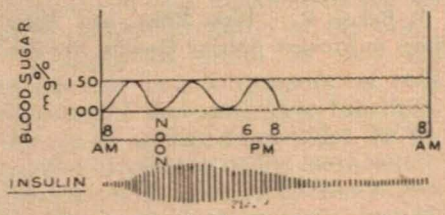


Figure 2

Control of the blood sugar in a non diabetic

In the diabetic under treatment insulin is injected once or twice a day under the skin where it forms a small pool which gradually releases insulin throughout the day regardless of the blood sugar level. Thus, food must be administered at regular intervals during the period of insulin action in order to avoid dangerous dips of blood sugar (see *Fig. 3).*



Control of the blood sugar in a diabetic receiving insulin

Missing a meal would result in such a dip and lead to nervous symptoms referred to as a hypoglycemic reaction (see *Fig. 1).* Nervousness, "shakiness," change in personality, hunger, visual disturbances and cold perspiration are classical signs of hypoglycemia. The child himself, his parents, teachers and close associates should be forewarned and taught how to recognize and treat this disturbance by rapid administration of sugar. Following one's diet greatly helps in preventing reactions.

Exercise is also a frequent cause of hypoglycemia. While exercise is good and highly recommended for diabetics, It is mandatory that its effect on blood sugar be understood and appropriate measures taken to avoid reactions. Exercise acts like an extra dose of insulin thus rapidly lowering the blood sugar. When a diabetic exercises he should protect himself against hypoglycemia by either increasing his intake of food or lowering his insulin.

The dose of insulin tends to vary a little from day to day. Variations in diet or exercise, the presence of infection (which increases the body's need for insulin) and changes in mood (through its effect on the endocrine and nervous systems) account for this variability. How then can patients maintain good control? It is the frequent testing of their urine for sugar which will guide them in the daily adjustment of their insulin. In case of doubt they will consult their physician, but he too will be guided by the record of the patient's urine tests.

What then must the young diabetic do to stay healthy? In a word he must learn to provide artificially what normally his pancreas ought to be doing for him (see *Fig. 2* and *3).*

1. He will inject into himself a daily

quantity of insulin appropriate to his needs.

2. He will examine his urine for sugar three or four times daily. The results obtained will guide him in the adjustment of his daily dose of insulin. *Fig. 4* outlines an easy way to keep a record of these tests. Using a hard covered notebook and colored pencils, a permanent record is produced that can be taken to the doctor's office.

3. He will follow the diet prescribed for him. This will contain sufficient calories to allow for normal growth and will be divided into three meals and three snacks which will ensure maintenance of a normal blood sugar throughout the day.

4. He will protect himself from hypoglycemic reactions by decreasing his insulin or raising his diet on specially active days.

5. He will take additional insulin during infections when the urinalysis indicates spillage of sugar or acetone.

Who is to be responsible for all this care? If the child is young, naturally, it will be in the parents' hands, but the child himself should be encouraged to take over his control early. He can be taught to do his urine tests by the age of six, to take his own insulin between seven and nine, and to understand the principles of his diet by nine or ten. Between twelve and fourteen he should be self-sufficient, looking for help directly to his physician rather than to his parents. Teen-agers are anxious to free themselves of parental authority—they will usually better accept direction if it comes from their doctor rather than second-hand via the parents. This is a difficult period for any child—probably more so for the diabetic. Parents should realize that the time has come for their child to assume responsibility for his own control, that mistakes will be made, but that this is better than risking constant conflict by imposing rules which he will not accept in any case. At this age discipline must come from within.

Lastly, one should not look upon diabetic children as being sick; when under good control they enjoy excellent health and they should be encouraged to engage fully in all activities available to them. Over-concern and uncalled for sympathy should be avoided. Certainly one should never excuse laziness in school work or failure to perform daily chores because of the fact that a child has diabetes. There is no more unpleasant person than a diabetic who learns to manipulate his parents and environment through his disease. Life will demand as much of diabetics as of anyone else and they should learn to compete on an equal basis with non-diabetics. In fact there is still much prejudice abroad concerning employment of diabetics—a difficult fact to face at any time, but that much more difficult if one has been pampered. A firm attitude, tempered with understanding and love, is the best preparation for life parents can give their diabetic child.

Fig. 4. Record of daily urine tests

Date	8 A.M.	Noon	5 P.M.	8 P.M.	Reaction	Insulin
June 10	bl.	gr.	bl.	or.	11.15 A.M.	10 CZI 30 NPH
June 11						

The number of calories we spend varies with the type of exercise and with the individual. Obese persons expend more energy than non-obese persons in performing the same task. In general, however, we spend 200-300 calories per hour in walking, 200-400 in dancing, 300-900 in swimming, 300 in golfing, and 800-1000 in running.

— *Patterns of Disease*

Requested the patient: "Doctor, if there is anything wrong with me, don't frighten me half to death by giving it a long scientific name. Just tell me in plain English."

"Well," the doctor replied hesitantly, "to be perfectly frank, you're just plain lazy."

"Thank you, doctor," murmured the patient. "Now give me the scientific name so that I can tell the family."

NURSING IN HONG KONG

SHIRLEY TONG

An interesting account of hospitals, curricula of schools of nursing and nursing conditions in Hong Kong.

Hong Kong, a British colony, is a small island, 400 square miles in total area, located on the east coast of China. It is divided into three sections: City of Victoria, Kowloon and New Territory. Approximately three million people live in Hong Kong, the majority being Chinese. There are also British, American, European, Portuguese and Indian groups situated on the island. The climate is sub-tropical with summer temperatures averaging 90° F. Tropical storms may occur any time from July to October. In winter, a fall below 40° F. is very rare.

There are 20 hospitals in Hong Kong: a tuberculosis sanatorium, communicable disease, maternity, mental and general hospitals. Half of these hospitals are government supported. The charge for patients in government hospitals is less than that in private hospitals; consequently the majority of people go to the former since medical insurance is not provided. The only government hospital that is not filled with patients is the sanatorium. In 1959 only half of the beds in this institution were used although the incidence of tuberculosis is high. Many persons with this disease do not stay in the sanatorium because of their inability to pay for prolonged hospitalization. A new general hospital containing 2,000 beds is now being built. It will be opened in 1964 and will have a school of nursing as well as a medical centre.

Seven hospitals have schools of nursing. Approximately 40 students are accepted into each of these schools every six months to begin their three-year nursing program. In order to be accepted, applicants must possess their junior matriculation diploma. Many applications are rejected each year.

During the first year, students are taught the basic nursing subjects. When they have completed three months of the course, they write an examination based on these subjects. Medical, surgical, pediatric and gynecological nursing are studied in the second and third years. Pharmacology and dietetics are also required subjects, but psychiatric and obstetrical nursing are not included in the curriculum. A graduate who wishes to become a midwife must spend one additional year studying obstetrical nursing. It is interesting to note that students in the basic program receive two days off each month — not each week!

One postgraduate course in nursing is available in Hong Kong. This is a one-year public health course given by the medical department. Graduate nurses who have had at least five years clinical experience are eligible. Many nurses apply but few are accepted. Recently the medical department announced that more scholarships would be available for postgraduate study in England. This was good news for many nurses.

There are numerous clinics and outpatient departments on the island. Health centres, maternity units and mobile clinics have been set up by the government. A team of three or four nurses works in the mobile clinic. They travel by boat between some of the small islands, and by car, plane or on foot to visit some of the villages. Most of the work done by these teams consists of tuberculosis surveys, inoculation programs, and health teaching.

The salary of a newly graduated R.N. is 500 Hong Kong dollars. This is equivalent to approximately 100 Canadian dollars. The cost of living is low and a nurse without dependents can live quite comfortably on this salary.

Nursing in Hong Kong differs in many ways from nursing in Canada. Certainly in one respect it is the same — changes are occurring — and nurses will be directly affected by these changes.

JOB SATISFACTION

in Hospital Nursing

CAROL ANNE SMITH, B.SC.N.

Job satisfaction in hospital nursing is dependent upon certain criteria being met. This study attempts to prove the hypothesis that the greater the number of these criteria present in a work situation, the more likely is the nurse to find satisfaction.

A great deal is heard and read about the changing role of the nurse, the so-called flight from the bedside, and the dissatisfaction that this is breeding among members of the nursing profession. The quantity and variety of complaints made by nursing personnel, both on and off duty, raises the question of whether or not the majority of nurses are satisfied in their jobs. This question is very important not only from the nurse's viewpoint but from the patient's also.

The primary purpose of a hospital is to meet the needs of the patient. The responsibility of the nurse is to meet the requirements for nursing care. The immense scope of the nurse's role has been outlined by Virginia Henderson in *Basic Principles of Nursing Care*, an ICN publication. The nurse must help the patient to fulfil his basic needs:

> to breathe, eat, and drink; to eliminate; to move and maintain desirable posture; to sleep and rest; to select suitable clothing; to maintain body temperature; to keep his body clean; to avoid dangers in the environment; to communicate feelings, emotions and needs to others; to worship according to his faith; to work at something that provides a sense of accomplishment; to play or participate in various forms of recreation.

The nurse's plan of care will be influenced by the patient's age, sex, temperament, social and cultural status, emotional make-up, physical and intellectual capacity, and by pathological states such as shock, fever, infection, dehydration and depression. The nurse's task is tremendous. She must be satisfied in her job if she is to perform at an optimum level. If she is dissatisfied she is not motivated to give her best. The patient suffers the consequences in that he does not receive the care he deserves.

Psychologists have established that there are many motivating factors in human life. These have been categorized by Carroll in his book, *Mental Hygiene* as:

> The need for emotional security; the need for achievement; the need for recognition or status; the need for physical satisfaction.

If the worker's needs are being met, he will be satisfied; if these needs are not being met, he will be dissatisfied in his work situation.

In 1955, at a meeting of the nursing section of the Ontario Public Health Association, the problem of frequent staff changes in public health nursing services was discussed. A study was undertaken to determine the factors contributing to job satisfaction in this field. The factors basic to job satisfac-

tion as indicated by the data collected* were:

A well-defined nursing role; a variety of tasks; adequate staff; freedom to plan one's own work; adequate education; preparation, and orientation; recognition of work well done; adequate vacation and sick leave time; satisfactory working hours; ample salary; a feeling of belonging to the agency; opportunity for promotion.

Although the conclusions reached were not definite, they have implications of general importance.

The condensed report of a study** by Mary Grivest indicates the attitudes of nurses toward their work. The author surveyed four hospitals in order to discover the extent to which supervisors, head nurses and staff nurses derived job satisfaction within categories established for measuring attitudes. Of the 215 nurses in the study, the majority revealed dissatisfaction with their hours of duty and with lines of communication while expressing satisfaction with their salary, physical working conditions, status, and relationships with co-workers.

Criteria for Job Satisfaction

With the help of data from other sources, I have established seven broad criteria for job satisfaction in hospital nursing. These criteria include the various factors that I believe affect the amount of job satisfaction a nurse will derive from her work. They are: *desire, preparation, discipline, personal living, physical conditions, remuneration, and attitudes.*

Desire

A genuine desire to nurse is basic to job satisfaction. Young girls applying for entrance to schools of nursing invariably state a desire to help their fellowmen as a motive. How many realize the deep meaning of this statement? If they are genuinely altruistic, they have a solid framework upon which all other factors leading to job satisfaction can rest.

Some choose nursing, however, because of opinions that they have formed from inaccurate representations of the nursing profession in books, movies and television. The individual visualizes herself as a ministering angel, efficient in a crisp, white uniform, cool and collected while playing her role in a drama of tension and excitement, and ultimately marrying a handsome doctor. A cartoon once showed a pretty teenager admiring herself in a mirror. The caption read, "White does something for me. I think I'll be a nurse!" This is a fictitious and extreme example, but it serves to illustrate the fact that there are other possible motives for choosing nursing in addition to altruism.

There must be some degree of altruistic motivation before there can be complete job satisfaction for the nurse. Real satisfaction in what she does lies in the knowledge and the recognition that she has given something of herself for the sake of another.

Preparation

To be satisfied in her job a nurse should feel secure in the knowledge and skill that she possesses. This implies preparation through an educational program that offers adequate instruction in theory and experience in practice. As a student, the nurse not only needs guidance in learning anatomy, physiology, and pharmacology, but also in acquiring such arts and skills as observing, listening, communicating, and empathizing. The body of knowledge inherent in nursing is vast and limitless. No one educational program can hope to teach all there is to know about nursing. It is very important that the student should absorb all she can during her learning experience. There is a human tendency to fall short of this goal and, for the purpose of examinations, to cram knowledge that is soon forgotten.

Basic nursing education should whet the appetite for more knowledge. Unfortunately, some nurses fail to make education an on-going process. With no goal of self-growth, their lives are characterized by frustrations, complaints, and feelings of inadequacy,

*Hazel E. Fletcher, "Job Satisfaction," *Canad. Nurse*, Vol. 53 (Sept. 1957), p. 812.

**Mary Grivest, "A Personnel Inventory of Supervisors, Head Nurses and Staff Nurses in Selected Hospitals," *Nursing Research*, Vol. 7 (June 1958), p. 77.

insecurity, and lack of fulfillment. They are on a treadmill of dissatisfaction, finding little or no pleasure in what they are doing while resting complacently on their laurels—a diploma and registration. The nurse who is given and makes use of opportunities to learn more about herself and her work through books, journals, staff meetings, nursing care conferences, self-evaluation and evaluation conferences, will be happier and more content in her job.

Discipline

A nurse who is new in her job requires close supervision and guidance. She is rendering service where human lives may be at stake. Conforming to rules, regulations, and procedures will not only ensure the safety of the patient but will give the nurse more confidence and security.

As she becomes adjusted, she needs an opportunity to exercise her own initiative and judgment. She should be able to obtain guidance when she needs it, while enjoying a certain amount of freedom. There should be opportunity for advancement since nothing is more frustrating than to be capable of doing more than one is permitted to do. It has been proven experimentally that the person who functions at the highest level of his ability most of the time, is the most effective and the happiest worker. Often, a marked improvement in morale can be effected by a slight rise in job status. Careful examination of the job description and the abilities of the nurse are important before promotion is made. She should not be placed in a position where she is unable to achieve a reasonable degree of success.

Implicit in the progression from close supervision and guidance to more freedom, responsibility and self-discipline, is the tool of evaluation. Evaluation conferences enable the nurse to recognize her good working habits and retain them; to discover her weaknesses and overcome them. Through constant evaluation she will learn and grow; she will enjoy a feeling of progress and accomplishment resulting in job satisfaction.

Involved in this criterion of discipline is the question of praise versus reproval. To oversimplify a very complex problem, it might be said that there are two ways to discipline a worker's performance: to *praise* for doing the right thing and to *reprove* or punish for doing the wrong thing. Much thought and experimentation have been concentrated on this problem to determine which of these methods achieves the better results. Evidence favors praise over reproof.

Personal Living

Ideally, one's job should not interfere with one's personal living. It is, however, an accepted fact that nurses are often called upon to render services beyond the call of duty, e.g., working over-time. Since patients require care 24 hours a day every day, nurses must work shifts and holidays. We frequently hear complaints about this irregularity of working hours, and about the insufficient notice given of days off duty. These factors do interfere with the planning of the nurse's personal life.

Because of understaffing in many hospitals, nurses are too tired to enjoy their leisure time. One author states that the nurse who consistently falls into bed as soon as she leaves the ward is living on the edge of danger; her life will resolve itself into a cycle of work—eat—sleep, day after day, until she loses all zest for living.// The same author urges nurses to take an active interest in sports, hobbies, clubs, etc. The nurse who concentrates exclusively on nursing has an unhappy and boring time of it; she seldom gains satisfaction from her work.

The nurse's personal living habits also affect her job satisfaction. If she comes on duty after a late night having had only coffee for breakfast, her day could easily be filled with frustration and dissatisfaction. If she comes on duty well rested, fresh, neatly groomed and properly nourished, she is more likely to give of her best and derive satisfaction from a job well done.

Physical Working Conditions

The first factor within this broad

//Gladys Strahmann, "What Do You Do Off Duty?" *Amer. J. Nurs.*, Vol. 53 (Oct. 1953), p. 1232.

category concerns job orientation. Any individual beginning a new job is entitled to good orientation. All too often a nurse is assigned to give patient care on her first day; she learns the routines and procedures of the institution by trial and error. She will probably experience feelings of frustration, tension, anxiety, inadequacy, insecurity and dissatisfaction.

Another factor is that of a well-defined job assignment. A nurse will feel more secure and satisfied if she knows the definite limits and responsibilities involved in her job. She should also know the job description of all her co-workers; thus the chance of overlapping of duties is minimized, and friction and dissatisfaction are less likely to occur.

Communication is a vital factor in the physical conditions of a job. If channels of communication are closed, frustrations arise, errors are made and job dissatisfaction results. Written assignments of daily work, verbal and written reports and orders must be clearly understood. Observations, ideas, and plans should be shared by all co-workers. A nurse should feel free to go to her superiors for requests, guidance, and advice.

Physical surroundings influence job satisfaction. Evidence indicates that a deliberate effort to create favorable working conditions will be followed by increased job satisfaction. Facilities which contribute to a nurse's job satisfaction include: conveniently located treatment and utility rooms; an intercom system; an adequate supply of necessary equipment.

Remuneration

Dr. Hans Falck of the School of Social Work, University of Buffalo, stated, in an address he gave at a public health supervisors' conference, that a nurse who feels secure and appreciated in her work situation will derive as much satisfaction from this as from the amount of salary she receives. On the other hand, he believes appreciation of an individual's efforts is not enough. To have job satisfaction, a nurse should receive a salary commensurate with her preparation, responsibility and experience. Not only should salary increases be made as a nurse is promoted vertically; they should also be made on the horizontal scale according to the nurse's preparation, experience and job performance.

Attitudes

To obtain satisfaction from her work, a nurse should have certain attitudes towards it. Few nurses would disagree that the motivation for nursing reaches far beyond the problems of money, hours and working conditions. We commit ourselves to help those in need because we believe that all men have a right to be helped. Lyle Saunders write:

> Whenever and wherever the nursing function is performed, there are always present two indispensable components, the patient and the nurse — one needing, one giving.§

Nurses give of themselves so that others may have relief from pain, comfort, assurance, support, and, perhaps most important, the knowledge that someone understands and cares.

A nurse should have healthy attitudes toward herself and others if she is to experience job satisfaction. The nurse who is most skilful in interpersonal relations and who derives a high degree of inner satisfaction in relating to others, is the nurse who recognizes that differences in personality are going to result in differences in behavior. She recognizes that such differences are inevitable; she believes in the right of others to be different from herself. Her self-assurance remains secure even when situations arise in which she is disliked or unsuccessful.

Nurses need to have flexible attitudes. Members of the nursing profession are reputed to have cautious and reserved attitudes towards change. A nurse must be observant and intelligent enough to see the need for change if it is warranted. She should have the initiative and courage to institute necessary changes, the flexibility to adopt changes, and the maturity to accept conditions and limitations which cannot be changed. She must have faith in the philosophy of the hospital where she is working and be proud of her role in its contribution.

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§Lyle Saunders, "Permanence and Change," *Amer. J. Nursing*, Vol. 58 (July 1958), p. 970.

These seven broad categories constitute the criteria for maximum job satisfaction. In an ideal work situation, all would be present. I will hypothesize that *the greater the number of these criteria present in a work situation, the more likely is the nurse to have job satisfaction.*

Measuring Job Satisfaction

Job satisfaction is difficult to measure, yet it exists; whatever exists in some degree can be measured. It is characteristic of anyone whose job satisfaction is minimal to keep his opinions to himself, particularly if he feels that he is likely to be identified with a condition of dissatisfaction. In collecting data the methodology should encourage employees to express their honest feelings and reactions.

The two most common methods of assessing attitudes are the questionnaire and the interview. The questionnaire approach was chosen for this study.

This method allows the respondent to remain anonymous. If the individual knows that her answers cannot be identified, she is more likely to respond according to her true attitudes and feelings, making the data more valid. Problems arise in recording responses if the interview method is employed. A tape recorder or extensive note-taking may inhibit free interchange; waiting until the conclusion of the interview to record information, introduces errors of recall. The questionnaire offers more accuracy in the recording of responses and quantifying of data.

The Questionnaire

The first step in constructing the questionnaire was to survey the established criteria for job satisfaction. Statements relating to these factors were then designed. From a preliminary group of 92 items or statements, 30 were chosen for inclusion in the questionnaire. These were closely related to the criteria of job satisfaction. The statements were designed to elicit definite responses. They were such that responses could be conveniently answered by "agree," "disagree" or "indifferent." An even wider range of possible answers such as "strongly agree," "agree," "indifferent," "disagree" and "strongly disagree" would probably have contributed to the validity of the data. In setting up the questionnaire, the items were arranged to avoid any logical sequence which might have affected the responses. For example, the two statements designed to test attitudes toward the criterion of remuneration do not appear together on the questionnaire; instead they are items number 10 and 16.

After the questionnaire was constructed, a favorable response was assigned to each statement. A *favorable response* was defined as one that reveals the presence of a factor contributing to an ideal work situation where the nurse can derive maximum job satisfaction. For example, the favorable response to the statement — "I have the proper equipment and supplies to do my work," is "agree." This is because one criterion for job satisfaction is that the nurse should have the proper equipment with which to work.

Remembering the hypothesis — the greater the number of criteria for job satisfaction present in a work situation the more likely is the nurse to have job satisfaction — it was expected that nurses who were generally satisfied with their jobs would have a high percentage of *favorable* responses; those who were generally dissatisfied with their jobs would have a high percentage of *unfavorable* answers. In addition to the 30 items one final statement was included: "I am satisfied with my job for the present." In the analysis of data, the response to this statement on each questionnaire was correlated with the number of favorable, unfavorable, and indifferent responses. The questionnaire that follows indicates the favorable response assigned to each statement.

Respondents

This study has been limited to one ward within a hospital setting. Owing to the small number of graduate nurses on the ward, it was necessary to include nursing assistants. Since certified nursing assistants are directly involved with patient care, work in the same physical job situation and carry out many of the same nursing functions as the graduate nurse, the criteria of job satisfaction formulated will generally

Sample Questionnaire

GRADUATE ——— NURSING ASSISTANT ———

Read each statement carefully. Please indicate your feeling towards each statement by circling "agree," "disagree" or "indifferent." There are no right or wrong responses. All answers are confidential.*

1. One of my early ambitions in life was to enter the nursing field.	*Agree*	Disagree	Indifferent
2. I can learn a great deal in my present position.	*Agree*	Disagree	Indifferent
3. There is too much pressure in my job.	Agree	*Disagree*	Indifferent
4. The education and training I have is not really adequate for my present job.	Agree	*Disagree*	Indifferent
5. There are many jobs available in this hospital for nurses who want to get ahead.	*Agree*	Disagree	Indifferent
6. My superiors seldom evaluate my work with me.	Agree	*Disagree*	Indifferent
7. My job is often dull and monotonous.	Agree	*Disagree*	Indifferent
8. I did not receive enough orientation when I began my job.	Agree	*Disagree*	Indifferent
9. Working shifts often interferes with my personal living.	Agree	*Disagree*	Indifferent
10. I am underpaid, considering my job qualifications and responsibilities.	Agree	*Disagree*	Indifferent
11. I have the proper equipment and supplies to do my work.	*Agree*	Disagree	Indifferent
12. I am proud to work for this hospital.	*Agree*	Disagree	Indifferent
13. I chose nursing as my work because it offered glamor and drama.	Agree	*Disagree*	Indifferent
14. I can be sure of keeping my job as long as I do good work.	*Agree*	Disagree	Indifferent
15. The people with whom I work assist each other in finishing patient assignments or coping with emergencies.	*Agree*	Disagree	Indifferent
16. I can live comfortably on my salary.	*Agree*	Disagree	Indifferent
17. I often feel tired and worn out on duty.	Agree	*Disagree*	Indifferent
18. There are changes that would make the ward more convenient for me to perform my work.	Agree	*Disagree*	Indifferent
19. My superiors sometimes show a lack of knowledge in their job.	Agree	*Disagree*	Indifferent
20. Some patients are unreasonable and difficult without a good reason.	Agree	*Disagree*	Indifferent
21. I always know the limits of my job and my responsibilities while on duty.	*Agree*	Disagree	Indifferent
22. My superiors keep me informed regarding new policies, orders and developments.	*Agree*	Disagree	Indifferent
23. I am in the habit of reading a regular nursing magazine or journal.	*Agree*	Disagree	Indifferent
24. I do not always receive enough guidance to feel secure in my work.	Agree	*Disagree*	Indifferent
25. Sometimes I feel that my job counts for very little in this hospital.	Agree	*Disagree*	Indifferent
26. By pooling ideas at team conference, my co-workers and I improve patient care.	*Agree*	Disagree	Indifferent
27. I do not have enough freedom to exercise my own initiative and judgment in my work.	Agree	*Disagree*	Indifferent
28. I feel free to go to my superiors with my problems at any time.	*Agree*	Disagree	Indifferent
29. I am really doing something worthwhile in my job.	*Agree*	Disagree	Indifferent
30. Because of my particular personality, I relate to some patients better than I do to others.	*Agree*	Disagree	Indifferent
31. I am satisfied with my job for the present.	Agree	Disagree	Indifferent

**Favorable answers are in italics.*

apply to both groups of respondents.

Fourteen questionnaires were distributed; twelve were returned. Six of those submitted were from graduate nurses, and six were from certified nursing assistants. Numbers one to six were assigned to the CNA's, seven to twelve to the R.N.'s.

Due to the limited number of individuals surveyed, no definite conclusions can be drawn. However, it is interesting to speculate on the implications of the results.

Analyzing The Data

The number of favorable, unfavorable and indifferent responses were totalled and tables were drawn up to compare values and percentages. A table appearing on page 000 shows, in terms of numbers and percentages, the results of the responses to each questionnaire statement. The first statement on the questionnaire received seven favorable and five unfavorable responses. Statement number 13 was assigned the favorable response of "disagree" and had a total of 12 favorable answers. This seems to reveal that nurses enter the profession seeking something more than glamor and drama. Statement number 21, with the assigned favorable response being "agree," had 11 favorable answers. This high total of favorable responses seems to imply that there is good job description and clear lines of communication among nursing personnel.

There were only seven unfavorable answers to statement number ten which was concerned with sufficient salary. One would expect a higher number of unfavorable answers since the salary schedule for most nursing positions is less than that of other professionnal workers. Perhaps the responses to this study reveal traces of the old-fashioned idea still lingering in the nursing profession today that nurses should accept whatever payment they are given without question since their high calling is over-and-above such mundane matters as salary.

The number and percentage of favorable, unfavorable and indifferent responses from each respondent was calculated. For example, respondent number one, a nursing assistant answered 20 statements favorably (60% of the total number), eight statements unfavorably (27%) and two statements indifferently (6%). This respondent expressed satisfaction with her job by agreeing with the 31st statement on the questionnaire: "I am satisfied with my job for the present." In most cases there was a high percentage of favorable answers; a medium percentage of unfavorable answers; a low percentage of indifferent answers. In the two cases (eight and eleven) where the percentage of unfavorable answers exceeds the percentage of favorable answers, both of the respondents expressed dissatisfaction with their job by answering "disagree" to the 31st statement. The 12th respondent whose response was "indifferent" to this statement had almost the same percentage of favorable and unfavorable responses (43% and 50% respectively).

Although the prime purpose of this study was to test the above-mentioned hypothesis, other implications can be made. The first criterion of job satisfaction is "desire." This criterion was represented on the questionnaire by statements number one and thirteen. The number of favorable responses for these two statements combined is 19 (or 79% of the total responses) and of unfavorable responses five (21%). This criterion of "desire" received the highest percentage of favorable answers. This would lead one to conclude that the majority of nurses have a certain innate desire to serve others. These altruistic motives are an important factor in contributing to the nurse's job satisfaction.

The criterion of "personal living" received the lowest percentage of favorable answers. This implies that factors such as irregular hours of duty and holiday time do contribute to a nurse's dissatisfaction with her job. Conditions pertaining to the criterion of "personal living" leave much to be desired as indicated by the 59% of unfavorable answers from respondents. However, progress is being made in this area. Nurses now have the 40-hour week and the "split shift" is less common. Perhaps in the ward situation itself, time schedules could be posted well in advance to facilitate personal planning.

The category "physical conditions"

Table of Responses to Each Questionnaire Statement

Item No.	F Resp. to Item	Total F Resp. No.	%	Total F Resp. CNA No.	%	Total F Resp. Grad. No.	%	Total U Resp. No.	%	Total U Resp. CNA No.	%	Total U Resp. Grad. No.	%	Total I Resp. No.	%	Total I Resp. CNA No.	%	Total I Resp. Grad. No.	%
1.	A	7	58	5	84	2	34	5	42	1	16	4	66	0	0	0	0	0	0
2.	A	11	92	6	100	5	84	0	0	0	0	0	0	1	8	0	0	1	16
3.	D	7	58	4	66	3	50	5	42	2	34	3	50	0	0	0	0	0	0
4.	D	7	58	4	66	3	50	5	42	2	34	3	50	0	0	0	0	0	0
5.	A	9	75	4	66	5	84	2	17	1	16	1	16	1	8	1	16	0	0
6.	D	6	50	3	50	3	50	6	50	3	50	3	50	0	0	0	0	0	0
7.	D	10	83	6	100	4	66	2	17	0	0	2	34	0	0	0	0	0	0
8.	D	4	33	1	16	3	50	8	67	5	84	3	50	0	0	0	0	0	0
9.	D	3	25	2	34	1	16	9	75	4	66	5	84	0	0	0	0	0	0
10.	D	4	33	2	34	2	34	7	58	3	50	4	66	1	8	1	16	0	0
11.	A	9	75	4	66	5	84	1	8	0	0	1	16	2	17	2	34	0	0
12.	A	9	75	6	100	3	50	0	0	0	0	0	0	3	25	0	0	3	50
13.	D	12	100	6	100	6	100	0	0	0	0	0	0	0	0	0	0	0	0
14.	A	12	100	6	100	6	100	0	0	0	0	0	0	0	0	0	0	0	0
15.	A	8	67	6	100	2	34	2	17	0	0	2	34	2	17	0	0	2	34
16.	A	5	42	3	50	2	34	6	50	2	34	4	66	1	8	1	16	0	0
17.	D	5	42	4	66	1	16	5	42	0	0	5	84	2	17	2	34	0	0
18.	D	4	33	3	50	1	16	8	67	3	50	5	84	0	0	0	0	0	0
19.	D	6	50	4	66	2	34	3	25	0	0	3	50	3	25	2	34	1	16
20.	D	2	17	2	34	0	0	10	83	4	66	6	100	0	0	0	0	0	0
21.	A	11	92	6	100	5	84	1	8	0	0	1	16	0	0	0	0	0	0
22.	A	9	75	4	66	5	84	3	25	2	34	1	16	0	0	0	0	0	0
23.	A	6	50	2	34	4	66	6	50	4	66	2	34	0	0	0	0	0	0
24.	D	3	25	2	34	1	16	9	75	4	66	5	84	0	0	0	0	0	0
25.	D	6	50	3	50	3	50	6	50	3	50	3	50	0	0	0	0	0	0
26.	A	10	83	6	100	4	66	2	17	0	0	2	34	0	0	0	0	0	0
27.	D	4	33	2	34	2	34	6	50	3	50	3	50	2	17	1	16	1	16
28.	A	10	83	6	100	4	66	2	17	0	0	2	34	0	0	0	0	0	0
29.	A	8	67	5	84	3	50	3	25	0	0	3	50	1	8	1	16	0	0
30.	A	5	42	0	0	5	84	7	58	6	100	1	16	0	0	0	0	0	0

Grad. = Graduate Nurse C.N.A. = Certified Nursing Assistant

Key:

A = agree F = favorable
D = disagree U = unfavorable
No. = number I = indifferent
Resp. = Responses

had a 31% response of unfavorable answers. Many hospitals are carrying out job analysis studies and formulating job descriptions for their employees. Good orientation programs have been set up. When it comes to improvements in working facilities, who is better qualified to advise, than the nurse herself? It is she who uses the hospital ward supplies and equipment that are supposed to make the patients more comfortable and save time and labor. Seventy-five per cent of the total respondents expressed satisfaction with their job; 17 per cent expressed dissatisfaction, and eight per cent expressed indifference. Of the certified nursing assistant group, 100 per cent expressed job satisfaction.

Why is dissatisfaction present in the graduate nurse group?

Perhaps part of the reason is the changing role of the nurse. Traditionally, her role was at the bedside; the successful practitioner derived much satisfaction from the relationship that existed between the patient and herself. Today, this role is threatened; it is danger of being replaced by a more technical one. As the process of change in duties sets in, nurses become unhappy. It is quite possible that many nurses in the near future will need to find satisfaction in directing and supervising nursing care rather than in actually giving it.

Summary

The major concern of this study has been to investigate job satisfaction in hospital nursing. The criteria that were formulated seem sound since the data revealed that upon their presence depends the nurse's satisfaction.

It is the responsibility of the entire nursing profession, through research, interpretation, and constant effort and enthusiasm to see that more and more criteria of job satisfaction are met. The one who ultimately benefits from the nurse's satisfaction is the patient.

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The hospital which uses the slogan "Grow or Go" for its staff has a scale of values and concerns that are different from those in the hospital which advertises the "programs" it offers its nursing staff. In some agencies, "having a program" seems to be the goal. The inservice coordinator will schedule monthly meetings for the staff with a speaker on specific topics, or demonstrations of procedures or new equipment . . .

If the consultant asks if the program is successful, she is handed attendance records, or is told the program is good because so many persons attended, or that there is a theme running through these monthly meetings for the whole year . . . In other words, "having a program" has become the goal . . .

Usually, at such an agency . . . administrators weigh and evaluate in terms of numbers, hours, measurements of people, and time. In contrast, the agency with the slogan "Grow or Go" pays more attention to the individual staff member. Here, the consultant learns that plans are made for staff members at all levels to attend institutes or meetings in the field in which they have special job interest. Groups get together voluntarily to discuss an article they have found challenging, or an idea they've heard about which they want to consider using . . .

The agency which emphasizes personal growth has more to say about patients, and the individual practitioner is judged by her effectiveness with patients. The visitor senses that all members of the staff respect each other.

What leads to this respect, this vitality? Basically, we believe, it is the treatment of staff members as individuals who are capable of assuming responsibility for their own growth, and giving them the opportunity to grow. This, in turn, encourages them to perceive their patients as individuals, and to help them become self-reliant and responsible once more for their own health and welfare . . .

— *Nursing Outlook*, September, 1962

Applications are invited for the position of

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Selections Committee

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School Improvement Program

In the December issue, mention was made that this program was ready to go into its third phase with workshops planned for early in 1963.

GLENNA ROWSELL, director of the program, leaves later this month for Calgary for the first of some 20 such workshops to be held throughout the country. She has planned one for each province, in some cases more. These workshops will endeavor to assist schools to meet their objectives of nursing. The results of Phase 2 of the program indicated that this area required the most assistance. Miss Rowsell will have competent leaders to assist her at each of the workshops. More details about the program will be available for next month's issue.

Royal Australian Nursing Federation

Word has been received in National Office that LORRAINE JARRETT has been named to succeed MARGARET MCNAUGHTON as executive director.

A graduate from the Brisbane General Hospital, Queensland, Miss Jarrett holds midwifery and infant welfare qualifications. She gained her sister tutor diploma at the College of Nursing, Australia, in 1956, and is a Fellow of the College. As a member of the Royal Australian Air Force Nursing Service for nine years, Miss Jarrett gained wide experience in administration. She was attached to the aero-medical evacuation unit in Japan and Korea. Later, she established the training department for medical orderlies and nursing sisters within the RAAF.

Following her resignation from the RAAFNS in 1959, Miss Jarrett was appointed deputy matron of the Townsville General Hospital and later assistant administrator of the New South Wales College of Nursing.

Our very best wishes to Miss Jarrett.

Visitors

A welcome visitor to National Office late in November was MARJORIE ELLIS of London, England. Miss Ellis, who is head nurse on the pediatric ward of The London Hospital, was touring Canada and the United States to observe the activities of new hospitals throughout both countries.

Canadian Nurses' Foundation

These words are near and dear to the heart of the CNA. How it came into being is explained on page 161 of this issue.

Committee on Nursing Service

This committee met with chairman EDNA ROSSITER in a stimulating two-day meeting at National Office in December. While some of the problems covered will be referred to the Executive Committee, much of the discussion centred around in-service education and nursing care needs of patients in general hospitals.

As the National Committee will not meet again for another year, Miss Rossiter, on its behalf, extended a vote of thanks to M. PEARL STIVER for her

valuable assistance and wished her well in her new endeavors.

Evaluation of Nursing Service

LILLIAN CAMPION, director of this study, returned to National Office in December following a six-week period at the New Mount Sinai Hospital. Toronto, where she was testing criteria for evaluating the quality of nursing service. She has now started on the next phase of this program. An up-to-date report of her activities will be presented in the March issue.

Miss Campion leaves for Fredericton to undertake a workshop on the quality of nursing service. This four-day conference is sponsored by the University of New Brunswick and will be held March 18-22.

International Competition

sponsored by the

Ethics of Nursing Committee

of the

International Council of Nurses

The subject of this competition, in which graduate nurses of all National Nursing Associations in membership with the ICN are invited to take part, is a *Pledge* for use in Graduation Ceremonies in schools of nursing based on the International Code of Nursing Ethics.

CONDITIONS OF ENTRY

1. The Competition is open to graduate nurses who are members of ICN Member Associations. If any question arises as to the eligibility of a contributor, the decision of the panel of judges shall be final.

2. The "Pledge" shall be typewritten on one side of the paper.

3. Each entry must be signed by a "Pen-Name." The name and address of the contributor must be enclosed in a sealed envelope, on which the pen-name is given, and attached to the manuscript.

4. A prize will be awarded for the winning entry which will be published in the *International Nursing Review*. No entry may be sent which has previously appeared in print.

5. The entry must be forwarded to the National Nurses' Association of the country concerned by the 31st of May, 1963. The closing date for national entries will be decided by the country concerned.

6. No entry submitted may be published in any nursing journal or in any other form without the permission of the International Council of Nurses. Entries will be returned to the writers after the results of the competition have been announced. For this purpose a self-addressed envelope should be enclosed with the original material with postage prepaid.

The "Students of Nursing Association of Prince Edward Island" was established recently. The objectives of this organization are as follows:

1. To promote fellowship among the students of nursing of Prince Edward Island.

2. To promote unity among the three students' councils of the three schools of nursing in the province.

3. To establish a revolving loan fund to be given to needy students.

4. To stimulate an interest in and an understanding of studies in nursing conducted by provincial and national nurses' associations.

* * *

Some folks are like blisters — they don't show up until the work is done.

— *The AMA News*

Nursing Profiles

Linda Rose Long was appointed advisor to schools of nursing in Saskatchewan late last year. A graduate of Yorkton General Hospital, Yorkton, Sask. in 1943, Miss Long obtained her bachelor of nursing degree from McGill University and her Master's degree from the University of Washington, Seattle.

Her nursing career to date has included considerable experience both in education and administration. She was assistant director of nursing, Yorkton General Hospital, for two years before accepting the responsibilities of assistant director of education and nursing arts instructor. In 1956 Miss Long joined the teaching staff of Saskatoon City Hospital as assistant director of education.

LINDA LONG

During the past year **Gladys McGregor**, a major in the Salvation Army, became administrator of Grace Hospital, Ottawa. A graduate of Winnipeg's Grace Hospital, Major McGregor studied teaching and supervision at the University of Toronto 1949-50 and has had further preparation in hospital organization and management. She has had considerable experience in supervision and administration as a former director of nursing, Grace Hospital, Vancouver and Grace Hospital, Winnipeg as well as assistant administrator of the latter institution.

GLADYS MCGREGOR

The Agnes Campbell Neill Award established by nursing sisters of both World Wars in memory of Colonel Agnes C. Neill, matron-in-chief, and granted biennially, was awarded to **Merle E. Smith**, a graduate of Hamilton General Hospital, for the 1962-64 biennium.

Miss Smith served with the RCAMC during World War II. She obtained her bachelor of nursing degree from McGill University and recently completed requirements for a Master of Science degree from Boston University. At present she is engaged in advanced professional study at the same institution. Miss Smith had a long-standing association with the Royal Victoria Hospital, Montreal where for several years she was instructor in operating room techniques and held supervisory positions in the nursing service.

She has always taken an enthusiastic interest in professional activities, holding office in the alumnae association of the McGill School for Graduate Nurses and in the Nursing Sisters' Association, Montreal Unit. She is a member of the Beta Sigma Phi, Exemplar Chapter, and of Sigma Theta Tau, the only national Honor Society of Nursing in the United States. A variety of

hobbies that include golfing, photography, sewing and building "hi-fi" sets occupies her off-duty time.

(Loring Studios, Montreal)

MERLE SMITH

An Australian nurse, graduate of the Bethesda Hospital, Melbourne, and a member of the Salvation Army, has become the administrator of Grace Hospital, Winnipeg. She is **Muriel Grace Everett.** A registered midwife and specially prepared in infant welfare work, Miss Everett is widely travelled. During World War II she worked in Palestine, Syria, Egypt, New Guinea and Singapore. She became administrator of the Grace Hospital, Vancouver in 1953, and was transferred to Grace Hospital, St. John's in 1960 in the same capacity. She left Newfoundland to come to her present post in Winnipeg. Miss Everett is a member of the American College of Hospital Administrators.

Blanche Eloise McKinney, a graduate of Saskatoon City Hospital, has been appointed assistant director of nursing, Sherbrooke Hospital, P.Q. Miss McKinney received her bachelor of nursing degree in hospital administration at McGill in 1961. Prior to that she had taken postgraduate study in obstetrics and ward management at the Margaret Hague Hospital, Jersey City.

General duty at Shaughnessy Hospital, Vancouver, and Kirkland and District General Hospital, Kirkland Lake was followed by experience as a head nurse, Royal Alexandra Hospital, Edmonton and as assistant head nurse in the Women's Pavilion, Vancouver General Hospital. Prior to accepting her present position, Miss McKinney was clinical instructor in obstetrics, Women's Pavilion, Royal Victoria Hospital, Montreal. During World War II she served in Canada and Germany as a nursing sister with the RCAF.

MURIEL EVERETT

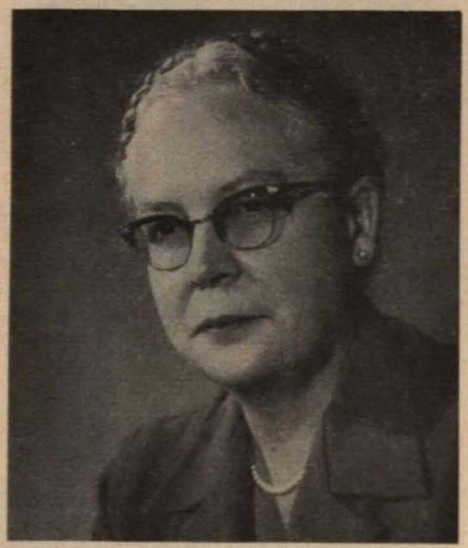
BLANCHE MCKINNEY

During 1962 the Hospital for Sick Children, Toronto announced the appointment of **Kathleen Durrell** as associate director of nursing education.

A graduate of the University of Alberta Hospital and of the University of Alberta School of Nursing, Miss Durrell obtained

her degree of Master of Nursing from the University of Washington, Seattle. She is a former director of nursing education, Winnipeg General Hospital.

For the past several years she was attached to the World Health Organization as a nurse educator in India, Iran and Jamaica.



KATHLEEN DURRELL

Sister Mary de Lellis, a graduate of the school of nursing and of the School of X-ray Technology, St. Joseph's Hospital, Saint John, N.B. was awarded a fellow membership in The American Society of X-ray Technicians in 1962. This is the highest honor granted by the Society in recognition of outstanding contributions to the profession of X-ray Technology. Only a selected few technicians have received the award. Sister obtained a bachelor of science degree in radiologic technology from St. Louis University, Mo. Her contribution to her profession has been a rich one.

Sister Madeleine de Jésus, with whose name the school of nursing, University of Ottawa has come to be so closely associated, retired as its director in 1962. Born in Massachusetts, Sister received her basic course in nursing at the Ottawa General Hospital and her bachelor of science in nursing education from the University of Ottawa. Later she completed requirements for her Master's degree in the same specialty at Catholic University of America, Washington.

Her professional career has been long and distinguished. Five years as an instructor in

SISTER MADELEINE OF JESUS

the Ottawa General Hospital were followed by five years in a similar capacity at the school of nursing, University of Ottawa. In 1938, Sister moved on to become administrator of St. Joseph's Hospital, Sudbury until her return to Ottawa in 1942 and the assignment of organizing postgraduate studies at the U. of O. With this task completed she remained on as instructor and assistant professor in nursing education until 1946. The succeeding years until 1952 were spent as school administrator, St. Joseph's Hospital, Lowell, Massachusetts. In that year, Sister returned to University of Ottawa, first as professor in nursing education, then as director.

Somewhere she has found time to contribute generously to various professional organizations. Among many other offices held, she was a member of the Executive Committee, CNA 1958-62; chairman, National Committee on Legislation and By-Laws 1960-62. The Victorian Order of Nurses, St. John Ambulance, and Royal Ottawa Sanatorium have all claimed her services in their respective advisory groups. Most recently Sister was appointed to the provisional council of Ontario's College of Nurses.

Former students, colleagues and friends everywhere will join in wishing Sister well in her retirement from the busy schedule of a school of nursing. Nevertheless, it is already clear that her abundant knowledge of her profession generally will be put to continued good use. Fortunately, her retirement is not absolute.

ANOTHER GOAL ACHIEVED

JUNE FERGUSON

"Into the future — open a better way." These words were spoken by the first president of the Canadian Nurses' Association.

November 21, 1962, saw another step forward toward keeping faith with this credo. It will be remembered by the CNA as a day of proud achievement and one of great significance. The first meeting of the board of directors of the newly incorporated Canadian Nurses' Foundation was held in Ottawa. Alice Girard, dean of the faculty of nursing, University of Montreal, was elected president; Ella Howard, director of nursing, New Mount Sinai Hospital, Toronto, vice-president; and M. Pearl Stiver, executive director of the Canadian Nurses' Association, secretary-treasurer.

At this historic meeting it was announced that funds totalling $150,000 over a six-year period had already been made available to the Foundation. This total will be augmented by funds raised by the Foundation itself. The money will be used to provide financial assistance each year to a number of nurses, with demonstrated leadership qualities, who wish to continue studies at the master's and doctoral levels.

"The kind of person we will be seeking to help and encourage," said Miss Girard, "is the nurse whose contributions have already added lustre to the profession, but who, with additional training, will be able and eager to contribute even more."

How It Came About

For many years the Canadian Nurses' Association had been conscious of the dearth of well-prepared nurses for key positions. It recognized the need to do everything in its power to ensure that there were Canadian nurses, sufficient in number and quality, to meet the ever-increasing challenge of nursing service.

Premised on the idea that nursing leaders should match the symbols of other professions, and that education is the forerunner of service, the first step towards their goal was taken in February 1961 at the CNA's annual executive meeting. It was decided to submit a request to the W.K. Kellogg Foundation, Battle Creek, Michigan, for a grant of $150,000, on a six-year plan, to enable the Association to give scholarships for graduate studies. The ultimate purpose would be to improve the quality of nursing service in Canada.

When this request was forwarded the following month, it met with sympathetic interest, but was not approved. The CNA was not a charitable organization. Donations could not be cleared for purposes of income tax

deduction. Clearly, more thought was required.

It became apparent that a foundation or trust fund would have to be set up so that donations could be included in income tax deductions. This required separate incorporation.

Through the efforts of Miss Stiver, inquiries regarding separate incorporation were made to the Department of the Secretary of State and the Department of National Revenue. At the meeting of the CNA Executive Committee in February, 1962, the preliminary steps were explored.

At this same meeting the development of the Canadian Nurses' Foundation was approved and a special committee was named to guide its formation : Katherine MacLaggan, who had prepared the submission to the Kellogg Foundation as a member of the CNA executive; Mary Richmond, a member of the CNA executive and chairman of the committee on nursing service; the CNA executive director, Pearl Stiver, as chairman; the CNA president, Helen Carpenter, ex-officio.

This committee met with the legal adviser to determine the many aspects of such an undertaking, not the least of which was urgency. The fiscal year of the Kellogg Foundation was fast drawing to a close. If the grant were not approved before the fiscal year ended, a new request would have to be made. This would involve some risk for the Association since the nature of other requests might influence the decision with respect to the Canadian Nurses' Association. In addition, the forthcoming biennial meeting of the CNA in June, 1962 could and would provide an excellent opportunity to interest individual memberships. Such an opportunity would not occur again for two years.

Diligent though the special committee was, the final clearance for the Foundation was still pending when the convention opened in Vancouver. However, arrangements were sufficiently advanced that the legal adviser could safely permit solicitation of memberships and donations.

A tentative selections committee was formed consisting of six members : Katherine McLaggan, Dr. Helen Mussallem, Ella Howard, Sister Madeleine de Jesus, E.A. Electa MacLennan and M. Pearl Stiver. Their duties were to establish criteria for the selection of candidates; decide upon the successful candidates for the 1962-63 academic year; outline a suggested application form for consideration by the Canadian Nurses' Foundation board. When the committee met on August 17, 1962, it already had 25 applications before it.

Each candidate's qualifications were reviewed carefully. Those who were eligible were ranked according to academic, personal and professional qualifications, financial need, proposed field of study, and nearness to completion of the graduate degree. A value in terms of financial assistance was designated to each rank.

On August 24, the W.K. Kellogg Foundation advised that it was ready to present the conditions under which the grant could be made. The only restricting clause was that the recipients must agree to practise in Canada upon completion of their studies.

Thus the Canadian Nurses' Foundation was launched, opening the way to meet the challenge of today and the future.

Its Objectives and Activities

To be both influential and useful, an organization must have objectives and activities. The New Foundation's objective is simply to assist in maintaining the highest possible standard of nursing service through advancement of the knowledge and art of nursing.

On the chairmen of four sub-committees rests the great responsibility of seeking those who will continue to make the greatest contribution to nursing in Canada; raising funds to keep the Foundation active; publicizing its activities; conducting research into special projects. These committees, under the slate of officers and the nine members of the board of directors, administer the affairs of the Foundation. There is an enormous amount of work ahead of them. Some of it is already underway; much remains to be done.

What Can Nurses Do ?

Men and women in the nursing profession are a privileged group. They

possess knowledge and skills vital to the peoples of the world. This privilege carries with it a responsibility to give of their human as well as their material resources.

The effectiveness of the work of the directors, officers and committees will be determined by the Foundation's membership. Active members provide increasing resources for a strong organization. Each nurse who claims membership helps to build the strength of the Foundation.

Your Foundation to date has some 300 members. It would welcome many, many more to its membership.

Your National Office has application forms available for the small membership fee of $2.00. You will have the satisfaction of knowing that you too are helping to open a better way into the future.

A great trust has been placed in the hands of the Foundation, as well as a great responsibility upon its administration. With unity of spirit, dedication of mind and the moral and financial support of the Canadian nurses, the Foundation will meet this trust and discharge its responsibility.

In Memoriam

Florence (Irving) Hicks (St. Jos. Hosp., Hamilton '20) died during September of last year.

* * *

The Alumnae Association of the Edmonton General Hospital pays tribute to the memory of **Marian (MacLeod) Howey '53** and **Aveline Winnifred MacDonald '30,** both of whom died during September, 1962.

* * *

Effa May Kerr (Orthopedic Hospital, Toronto '23) died in October, 1962.

* * *

Janet (Grimes) Laidlaw (Royal Jubilee Hospital, Victoria '42) died as the result of an accident early last year. She was on the staff of her home hospital at the time.

* * *

Alma Benoit-Lapointe (St. Joseph's Hospital, Three Rivers, P.Q. '36) died late in August, 1962 after a lengthy illness. She was the president of the Association of Catholic Nurses of Canada for 15 years.

* * *

The Alumnae Association of the Montreal General Hospital pays tribute to the memory of **Annie E. Lang** '12 and **Marjorie (McBride) Thomlinson** '29.

* * *

Gabrielle Lemay (Ste Justine's Hospital, Montreal '28) died in Montreal on November 15, 1962. Following a number of years with the medical social service unit of the hospital, she joined the staff of the neurological outpatient department of Ste Justine's Hospital.

* * *

Dora Mildred (Baycroft) Lister (Collingwood General Hospital, Ont. '34) died on October 25, 1962. She had engaged in institutional nursing.

* * *

Jessie Anne McDonald (St. Joseph's Hospital, Victoria '31) died in Vancouver on October 12, 1962.

* * *

Margaret May MacFarlane (Bath City Hospital, Maine '10) died in St. Stephen, N.B. during September, 1962. She had engaged in private nursing.

* * *

Olwen Matthews (Grace Hospital, Winnipeg '40) died early last year. She had served her hospital as a staff nurse, a head nurse and for several years as its purchasing agent.

* * *

Ruth Mary (Livingstone) Minnes (Niagara Falls General Hospital, Ont. '35) died during 1962.

Mary Eugenia (Toland) Neilson (Lowell General Hospital, Mass. '10) died in Kingston, Ont. during 1962. She was a former day supervisor of the Ann Baillie Nurses' Residence, Kingston General Hospital.

* * *

Jane Eileen (Whyte) Patrick (Wellesley Hospital, Toronto) died in September 1962. During World War II she served with the nursing staff of the Royal Canadian Navy.

* * *

Eva Jane Patterson, a Canadian nurse who served overseas during World War I, died in Toronto at the age of 83. She was decorated by the French government in recognition of her wartime contribution.

* * *

Grace L. (Boulton) Richards (Victoria Public Hospital, Fredericton '03) died recently in Fredericton. She was one of the earliest graduates of V.P.H. and was a former matron of the Fisher Memorial Hospital, Woodstock, N.B.

Evelyn Shaw (Kingston General Hospital, Ont. '44) died in Trenton, New Jersey, after a long illness.

* * *

Jessie Graham Stothart (Royal Victoria Hospital, Montreal '12) died in Winnipeg late in 1962. She had retired from her work as a public health nurse in Manitoba in 1948 after 28 years of service. She was a former assistant superintendent of nurses of the Vancouver General Hospital.

* * *

Anna I. Timlin (St. Joseph's Hospital, Toronto '26) died in 1962. She had engaged in private nursing.

* * *

Eva May Welsby (Ontario Hospital, London '27) died recently. She had retired from nursing some time previously.

* * *

Shirley (Cockrell) Wright (Victoria Union Hospital, Prince Albert, Sask. '53) died early in 1962.

A recent study by Dr. Jane Halliday, made at Teachers College, Columbia University, New York, represents a new approach to the problem of nurse-role expectations held by patients and nurses themselves. Dr. Halliday sought to identify desired qualities — ideal traits — that segments of the public considered to be of highest value in nursing care, and to formulate a composite ideal image of the professional nurse . . .

. . . The study involved 77 patients, 44 staff members, 667 graduate students, made up of 145 students in nursing education and nursing service, and 522 (both male and female) in non-nursing fields.

A situational question was posed in an interview with an initial group of 14 graduate students which enabled them to speak in terms of the positive values desired in a nurse . . . From this interview emerged 15 ideal traits. These represented two types of characteristics: *functional*, suggesting the skills or professional action of the ideal nurse — well-trained, punctual, instructive, efficient, neat appearance, non-specialized, communicative, and well-educated; and *expressive*, suggestive of feeling or interpersonal responsiveness — tender touch, sympathetic, anticipative, emphathetic, cooperative, happy, and supportive.

To determine which ones of the 15 ideal traits were rated highest, a rank-order questionnaire was devised. This exploration . . . reveals a composite picture that describes the ideal traits in the order of value placed on them by the respondents, as follows:

The ideal professional nurse is qualified to the degree of being proficient. That is to say, she really knows her job. Its most important for her to understand me; that is, she can put herself in my shoes, experience some of my problems. When she performs she really has the air of knowing her job. While she is performing her work, she expresses a sort of gentleness and friendliness. She is well-informed on other than her major role responsibilities. She is congenial with others, even though I am her primary concern. She appears to be happy. I don't mean that she is 'bubbling over' but she is a person who seems to be enjoying life. Whenever I need her most she is right there supporting me. I want to be able really to talk to her, and I expect her to be able to express herself well. Sometimes, even before I become uncomfortable, she will anticipate my needs and make me comfortable. When she performs a function she takes time to explain the *whys* and *hows* of it. She is always clean and well groomed. Finally, I guess I do want her to feel sorry for me at certain times.

International Nursing Review, August 1962.

HYPOSPADIAS

M. A. BAILEY

Peter has a three-stage surgical correction of a congenital malformation of the urethra.

Peter was a well-developed, active five-year-old who appeared to be in excellent health. He was admitted to hospital for a third stage hypospadias repair.

Definition

Hypospadias is a congenital anomaly in which the urethra opens on the under surface of the penis instead of at the tip of the glans. Minor degrees of hypospadias are common and do not require treatment. Surgical correction will ultimately be required when the urethral meatus is between the glans and the penoscrotal junction.

Diagnosis

The discovery of an abnormal urethral opening may not be made until the child has outgrown diapers. During the diaper age it is doubtful that the mother will notice the abnormal stream of urine. Attention is usually drawn to the anomaly by the hooded appearance of the foreskin; closer examination of the penis shows the retrocessed position of the urethral opening. When the orifice is in the mid-shaft of the penis, the condition frequently goes undetected in infancy; later in life there is wetting of the surrounding floor, clothes, and shoes during the act of urination. If the urethral opening is at or near the perineum (scrotal hypospadias) the deformity is usually noted at birth. When this type is present, the boy must sit down to void — a situation that generally does not disturb him until four to six years of age. Then, other children become aware of the fact that he does not stand up to urinate like other boys. The need for early surgical correction is obvious.

Peter's condition was recognized at birth and diagnosed as penoscrotal hypospadias. The penis was partially bound down at its base by fibrous connective tissue, causing a condition of chordee.

Surgical Correction

Surgery is generally carried out in three stages. The objective is to reconstruct the urethra so that the opening is near the end of the penis.

First stage: This consists of a surgical division of the adhesions to relieve the chordee. This surgery frees the phallus for normal growth. Peter received this treatment when he was two — the usual age for this stage of repair.

Second stage: During this stage, a plastic reconstruction of the urethra is attempted. Usually this is deferred until there has been adequate growth of the structures involved. Peter was admitted for this phase of the repair at four years of age.

Reconstruction entailed the use of a tubular graft to line an artificially-made urethral pathway extending from the existing urethral meatus to the tip of the penis. In order to keep the operative field dry, a Foley catheter was inserted through the existing meatus into the bladder.

Postoperatively, the penis was immobilized. It was held upward against the pubic arch and lower abdominal wall with a soft compression dressing. Ten days later, the Foley catheter was removed and Peter was discharged

from hospital. Another catheter inserted through the newly made urethral channel was left in place until the third stage of repair. This acted as a strut to prevent any narrowing of the urethra during the subsequent months. It was necessary for Peter's parents to learn how to change the catheter daily.

Third stage: Twelve months after the construction of the penile urethral pathway, Peter was readmitted for an anastomosis of the urethra to the original urethral meatus. Ten days postoperatively, he was able to void through the newly constructed urethral pathway.

Specific Nursing Care

The nurse must gain the child's friendship and trust. Peter's nurse was able to establish good rapport by showing kindness, affection, and a genuine interest in him. She encouraged his parents to discuss his condition, thus giving them an opportunity to express any fears or feelings that they might have concerning his treatment. Parents who have confidence in their child's treatment and progress are better able to provide a sense of security in the child himself.

Postoperatively, Peter was given clear fluids only, per os. It was essential that his fluid intake exceed the normal amount taken by a four-year-old. In no other type of surgery is the intake of adequate fluid so important as in conditions of the genito-urinary tract. Fluids lessen strain on the kidneys by diluting the waste products. When a catheter is in place, a free flow of diluted urine is essential in order to prevent urinary stasis. It was necessary for Peter's nurse to provide a variety of fluids for him, and to keep an accurate account of his intake. Four days postoperatively a regular diet was ordered along with the extra fluids. He tolerated this diet well.

Urinary output must be measured as accurately as fluid intake. In Peter's case, the urine was directed from the catheter into a winchester that was emptied and measured every 24 hours. If the intake is adequate, the output should be from 500 to 750 c.c. Diminished output must be reported promptly. The nurse should watch for any signs of hematuria or pyuria. Catheter irrigations were not ordered.

Suture-line care is essential in order to prevent infection in the operative site. A sterile suture-care tray was set up and ready for immediate postoperative use. This care was given every four hours and after each voiding. The solutions used for Peter's incision were hydrogen peroxide, sterile water and alcohol.

The nurse realized that play is an important aspect of a child's therapy. She provided Peter with a variety of playthings, including picture books, blocks, and toy cars. The attention span of the pre-schooler is short, and it required ingenuity on the part of the nurse to keep Peter occupied and happy while he was bed-ridden.

Ten days following his final surgery, Peter was discharged to his home. The three-stage surgery had been successful.

References

1. Blake, Florence. *The Child, His Parents, and the Nurse.* Montreal, J. B. Lippincott, 1954.

2. Gross, R. *The Surgery of Infancy and Childhood.* Philadelphia, W. B. Saunders, 1953.

3. Paterson, Donald, and J. F. McCreary. *Pediatrics.* Montreal, J. B. Lippincott, 1956.

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MARCH 1963

SERIES ON REHABILITATION

Articles by Executive Director, Director of Nursing, Medical Director, Occupational Officer, Psychologist, Psychiatrist, medical social worker and others at the Rehabilitation Institute of Montreal.

About Books

Aids to Psychology for Nurses by A. Altschul, B.A., S.R.N., R.M.N. 308 pages. The Macmillan Company of Canada Limited, 70 Bond Street, Toronto. 1962.

This book is one of the "Nurses' Aids Series." The author's purpose is to "show what psychology really is about, and to examine if nurses in any part of their work can benefit from a knowledge of psychological facts."

In our opinion this book merely "scratches the surface" of general psychology. A nurse, like any other professional person, should study texts which deal with principles of psychology in more depth, describe experiments, etc. It is not enough to study material that is obviously diluted and gives ". . . just that quantity of information which the nurse needs to possess."

The Cure Searchers by Max Braithwaite, 173 pages. The Ryerson Press, 299 Queen St. W., Toronto. 1962.

This book has been written for readers between the ages of twelve and sixteen. It is "an authentic account of cancer research built within an entertaining story."

She Loved a Wicked City by Lawrence Earl. 240 pages. McClelland & Stewart Ltd., 25 Hollinger Road, Toronto. 1962.

This is the true story of Mary Ball who was for 25 years a missionary nurse in the city of Tatung on the Mongolian border of China. Nurses should find this book interesting and inspirational.

Medicine Today by David Margerson. 112 pages. Penguin Books Ltd., Harmondsworth, Middlessex. 1961.

This illustrated pocketbook would be of interest to the layman. The author discusses topics such as immunization, diagnosis and treatment of disease in a clear and concise manner.

Oral Surgery for Nurses by F. G. Hardman, M.B., Ch.B., B.D.S., F.D.S., R.C.S., M.R.C.S., L.R.C.P. 112 pages. The Macmillan Company of Canada Ltd., 70 Bond Street, Toronto. 1962.

This book would be of interest to nurses working in an oral surgical unit. Contents include: Anatomy of the parts concerned; an outline of routine work; oral surgical nursing in the wards; assisting in the theatre; assisting in the out-patients' department.

Vocational and Technical Training for Girls. 45 pages. Women's Bureau, Department of Labour of Canada. 1961.

This publication deals with careers available to young women. It lists the courses offered at various educational institutions, and the requirements for admission.

Psychology: Principles and Applications By Marion East Madigan, Ph.D. 379 pages. The C. V. Mosby Company, St. Louis, Mo. Ed. 3. 1962.
Reviewed by Lois Smith, director of nursing, Provincial Hospital, Lancaster, N.B.

The purpose of this book is to present psychology as a dynamic discipline for the beginning student of nursing. It goes on to show the many disciplines involved in understanding the behavior of man. The author points out the value of psychology in learning to get along with others; adjusting to a new environment; understanding of self; acquiring efficient study habits. All of these areas are expanded in later chapters.

In order to understand human behavior it is necessary to have some knowledge of development, both physical and psychological. The student is supplied with ample material in this field. The effect of environment on development and personality formation is discussed with examples to clarify points. Individual differences are stressed and a whole chapter is devoted to the explanation of the use of tests and measurements in determining individual differences and potential.

Part of the book deals with mental health. This should be of assistance to the young student in adjusting to the many stresses that she is subjected to daily. Personality disorders, psychoses, neuroses and the effect of illness on the individual are included. This should help the student to understand the behavior of patients better. The final chapter discusses the aged and their nursing needs, knowledge that is essential for the modern nurse.

This text would be an asset to the library of any school of nursing. It would be of special value to the young student in her study of man, his adjustments and maladjustments in everyday life. She should benefit from the guidance given in methods of study, reading skills and communications.

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People in Hospital by Elizabeth Barnes. 155 pages. Macmillan & Co. Ltd., St. Martin's Street, London, W.C. 2. 1961. *Reviewed by Dr. Margery R. King, Director of Education and Training, Canadian Mental Health Association, Toronto 4.*

This little book is a veritable gold-mine for anyone interested in the human problems encountered in a general hospital.

The book grows out of the International Study of Psychological Problems in General Hospitals sponsored jointly by the World Federation for Mental Health, the International Council of Nurses and the International Hospital Federation. General hospital personnel and mental health workers met in 18 small informal groups in nine countries in Europe and North America. The reports of their discussions, carried out over a two-year period, were in turn considered by an international group of experts. The author, a nurse and journalist, was the coordinator of the project. Throughout the book, she expresses not only her interest and understanding of the topic under discussion but also her warm human sympathy and humor.

This book neither pretends to be a research report, nor attempts to solve the problems of human relations in general hospitals. While almost all of the groups believed that many of these problems arose because of a breakdown in communication, most felt that there were no simple solutions that could be prescribed; that each hospital would have to find its own solutions based on its organization, personnel and relationship to the community.

The book and the discussions on which it was based cover a wide range of topics. It starts with the patient's problems on admission to hospital and how his needs are met by doctors, nurses, other hospital staff and other patients. There is an excellent presentation of the particular emotional problems created for doctors and nurses by the demands of the patient, and of the inter-relationship and isolation of the various hospital staff groups. The problems of children and of the aged are discussed with particular reference to the implications that the hospital organization may have in the maintenance of family ties. This naturally leads to a consideration of arrangements for the patient's return to his normal way of life and the relationship between the hospital and other health services in the community.

This is a thoroughly satisfactory book that raises more questions than it answers. It should stimulate many more discussions

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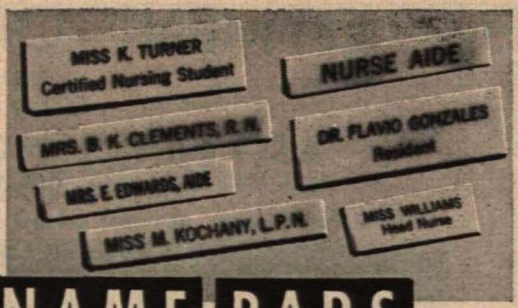

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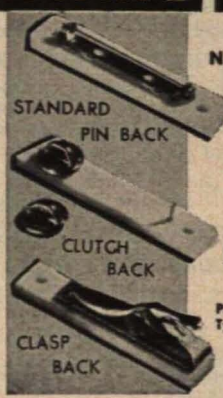

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with far-reaching effects in terms of increased communication about and understanding of human problems.

Illustrated Obstetrics for Midwives by J. M. Holmes, M.D., M.B., B.S. (Lond.), M.R.C.O.G. 116 pages. Butterworth & Co. (Canada) Ltd., 1367 Danforth Avenue, Toronto 6.

Reviewed by Grace E. Livings, Riveracres Apts., Prescott Road, Brockville, Ontario.

This book contains much valuable information to those interested in the practice of obstetrics. However, it is difficult to decide if the text was written for the special benefit of midwives, working single-handedly in a patient's home. Such statements as "chloral hydrate 60 gr. in 6 drams of water is given and may be repeated once 6 hours later," and "intramuscular injections of pethidine 100 mgm. are given to relieve the labour pains," suggests that it may well be useful for hospital delivery supervised by the mother's physician. The illustrations are excellent.

Dr. Holmes has reached his objectives to some extent. He has placed his emphasis on normal delivery. I feel, however, that it is somewhat lacking in practical display.

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Registered Nurses immediately for 54-bed hospital, basic salary $295 with 6 semi-annual increments of $5.00, group medical, hospitalization and pension plans. 40-hr.wk., 31 days' vacation after one year, accommodation in residence $35. Apply: Director of Nursing, Municipal Hospital, Vermilion, Alberta. 1-90-2

Registered Nurses for modern 20-bed hospital, commencing salary $350 per mo., accommodation and board $35.50. Recently renovated nurses' residence. Apply: Matron, Municipal Hospital, Myrnam, Alberta. 1-66-1

Registered Nurses & Certified Nursing Aides (immediately) for new 70-bed hospital. Salary $325 - $370; $200 - $240; 40-hr. wk., liberal personnel policies, experience considered. Apply: Sister Superior, Providence Hospital, **HIGH PRAIRIE**, Alberta. 1-45-1

Registered Nurses for General Duty for 95-bed active hospital newly opened. Salary as per AARN requirement. Good personnel policies. Apply to: Administrator, St. Theresa Hospital, P.O. Box 880, St. Paul, Alberta. 1-79-1

General Duty Nurses for well-equipped 76-bed hospital in active town of 3,000. Salary $290 - $340 for Alberta registered; $280 - $330 for non Alberta registered. New separate residence, excellent personnel policies & working conditions. Apply to: Director of Nursing, Brooks General Hospital, Brooks, Alberta. 1-13-1

General Duty Nurses. Starting salary: $300 per mo., 40 hr. work wk. Room, board & laundry, if desired, at nominal rates. Civil Service holiday, sick leave & pension benefits. Apply to: Baker Memorial Sanatorium, Dept. of Public Health, Calgary, Alberta. 1-14-3

NURSES fully qualified for 30-bed active treatment hospital. New hospital building & recently renovated nurses' residence. Unless definitely interested in coming, please do not apply. Personnel policies sent upon request. Apply to: Mrs. M. Hislop, Superintendent, Municipal Hospital, Bassano, Alberta. 1-5-1

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Psychiatric Unit: Nurses, preferably with P.G., for small, new unit in General Hospital. Services coordinated with new mental health clinic. Apply: Director of Nursing, General Hospital, Kelowna, British Columbia. 2-34-1

Royal Jubilee Hospital, Victoria, B.C. offers opportunities for challenging and stimulating employment in an expanding Operating Room Dept. Excellent personnel policies. Positions available: **Charge Nurse** (Responsible to Supervisor for service in an assigned area.) And **Scrub Nurses.** Apply to the Director of Nursing. 2-76-4

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General Duty Nurses for 82-bed hospital in Northwestern B.C., 1963 salaries B.C. registered $335-$402; non-registered $320, room & board $50 per mo., 10 statutory holidays, 1½ days sick leave, 4-wk. vacation, superannuation & medical plan coverage, fare advanced if required. Apply to: Director of Nursing, General Hospital, Kitimat, British Columbia. 2-36-1

General Duty Nurses for 110-bed hospital in northwestern B.C. Salary: non-registered $309, B.C. registered $324-$389. Travel allowance, newly furnished residence available. For full details contact: Director of Nursing, General Hospital, Prince Rupert, British Columbia. 2-58-2

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Nurses (2) for General Duty from January 1st in 17-bed acute hospital on the west coast of Vancouver Island. Salaries according to RNABC agreements & RNABC personnel policies in effect. Room & board in modern nurses' residence: $40 per mo. Apply by mail or telephone: Matron, General Hospital, Tofino, V.I., British Columbia. 2-71-1

General Duty, Operating Room & Experienced Obstetrical Nurses for 434-bed hospital with school of nursing. Salary: $309-$374. Credit for past experience & postgraduate training. 40-hr. wk. Statutory holidays. Annual increments; cumulative sick leave; pension plan; 28-days annual vacation; B.C. registration required. Apply: Director of Nursing, Royal Columbian Hospital, New Westminster, British Columbia. 2-73-13

Graduate Nurses & Certified Nurse Aides for new 75-bed hospital opened September 1962. Salary B. C. reg. Nurse: 1962 - $309-$374 — 1963 - $320-$387; salary Non-reg. Nurse: 1962 - $294 — 1963 - $305; Certified Nurse Aides: 1962 - $200-$221. RNABC personnel policies in effect, very active town in Cariboo ranching country. Apply: Director of Nursing, Cariboo Memorial Hospital, Williams Lake, British Columbia. 2-80-1

Graduate Nurses and Certified Nursing Assistants for 70-bed acute General Hospital on Pacific Coast. Salary for B.C. registered $309 with regular increments; unregistered $294; Nursing Assistants $205-$225. Board and room $25 per mo., 28-day vacation plus 10 statutory holidays after 1 year. Superannuation and medical plans. Apply: Director of Nursing, St. George's Hospital, Alert Bay, British Columbia. 2-2-1

Graduate Nurses for 60-bed modern hospital in resort area on Vancouver Island. R.N. basic rate $320/m with yearly increments according to RNABC personnel policies. Enquiries: Director of Nursing, Campbell River & District General Hospital, Campbell River, British Columbia. 2-9-1

Operating Room & Obstetrical Nurses, British Columbia registered, for modern 450-bed acute General Hospital, located on South Vancouver Island. Basic salary $309, credit for experience & postgraduate preparation, personnel policies in accordance with RNABC. For particulars write to: Director of Nursing Service, St. Joseph's Hospital, Victoria, British Columbia. 2-76-5

Nurses two for 30-bed hospital. Salaries as per B.C. Registered Nurses' agreement. Comfortable nurses' home. Apply to: Miss H. Campbell, R.N., Director of Nursing, Community Hospital, Grand Forks, British Columbia. 2-27-1

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Registered Nurses (2) for The Glenboro Hospital, Glenboro, Manitoba. Duties to commence as soon as possible. Starting salary for R.N.'s. — $330 per mo., residence accommodation available in modern, almost new residence. Glenboro is located between Brandon & Winnipeg on no. 2 Highway. Excellent social, religious & sporting facilities are available. Personnel policy manual mailed on request with no obligation. Applications to: Mr. S. A. Oleson, Box no. 130, Glenboro, Manitoba. Telephone no. 12, no. 17, or no. 52. 3-28-1

Registered Nurses (2) for fully modern 31-bed hospital. $295 per mo. with increase to $320 effective January 1, 1963. $45 per mo. for full maintenance. 40 hr. wk. 3 wk. vacation after 1 yr. Daily bus and train service to Winnipeg. Personnel policies supplied on request. For further information write or phone 190 collect to: Mrs. E. Sims, District Hospital, Roblin, Manitoba. 3-48-1

Registered Nurses (2) for 42-bed hospital located 38 mi. from Winnipeg. 1963 salary schedule $325-$370 per mo., 3 annual $15 increments. Credit given for experience, 40-hr.wk., complete maintenance $45 per mo. in modern nurses' residence. Usual holidays and sick leave benefits. For further information and application forms, write to: Miss Josephine Giesbrecht, R.N., Director of Nursing, Bethesda Hospital, Steinbach, Manitoba. 3-59-1

Registered Nurses for General Duty in 18-bed hospital. Salary $330-$390. Full maintenance $50 per mo., 40-hr.wk., generous personnel policies. Apply: Administrator, Community Hospital, Reston, Manitoba. 3-46-2

Registered General Duty Nurses (2 required for the Hunter Memorial Hospital, Teulon, Manitoba). 20-bed fully modern hospital, salary $330 per mo., 40-hr. wk., full maintenance available at the hospital for $45 per mo., increment of $5.00 every 6-mo. for 8 increases. Duties to commence immediately. For further information & application form apply to: Mrs. Olive Campbell, Matron, Teulon, Manitoba. 3-63-1

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Graduate Nurses (4 or more immediately). Basic salary: $305 plus allowance for past experience. $5.00 increments every 6 mo. Separate residence with room and board available at $45 per mo. Free laundry of uniforms. Group insurance available. Apply: The Administrator, or, The Matron, The Altona Hospital District No. 24, P.O. Box 600, Altona, Manitoba. 3-1-1

NOVA SCOTIA

General Duty Nurses for modern 35-bed hospital situated on beautiful South Shore. Good personnel policies. Excellent living quarters. Apply Superintendent, Fishermen's Memorial Hospital, Lunenburg, Nova Scotia. 6-21-1

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ONTARIO

Hospital Supervisor to act in the capacity as an Assistant Superintendent (must be a Reg. Nurse of Ontario (female) with O.R. experience) for General Hospital located in attractive community one hour from down town Ottawa. Good personnel policies and employer participation in pension plan and other benefits. Apply: Superintendent, District Hospital, Kemptville, Ontario. 7-63-1

Operating Room Supervisor with postgraduate course for active operating room in 86-bed hospital. Good salary and employee benefits. Apply to: Director of Nursing, General and Marine Hospital, Collingwood, Ontario. 7-31-1

Operating Room Supervisor (immediately) for active operating room in 250-bed hospital. Experience and postgraduate study necessary. Good salary and personnel policies. Please apply: Director of Nursing Service, Hotel Dieu Hospital, Kingston, Ontario. 7-66-1

Nursing Supervisors Registered Nurses and Cert. N. Ass'ts. Positions available on staff of 90-bed hospital. Community favorably located, 50-mi. south-west of Ottawa, 60-mi. north-east of Kingston; population 10,000. Apply to: Director of Nursing Service, St. Francis General Hospital, Smiths Falls, Ontario. 7-120-1

Operating Room Supervisor experienced with postgraduate training for modern 100-bed fully accredited hospital in planning stage of expansion to 200 beds. Attractive salary and liberal employee benefits. North Bay and adjoining municipalities are in central Ontario, equidistant from Toronto and Ottawa and have a population of 35,000. Apply: The Director of Nursing, Civic Hospital North Bay, Ontario. 7-88-1

Head Nurse & Assistant Head Nurse (Applications are invited) Vacancies pending. Starting salary dependent upon qualifications and experience. Head Nurse $355 - $365; Assistant Head Nurse, $345 - $355; excellent personnel policies, residence accommodation available. Apply: Director of Nursing, The Queen Elizabeth Hospital, 130 Dunn Avenue, Toronto, Ontario. 7-133-32

Registered Nurses for 100-bed General Hospital, salary $340 with four $10 increments, OHA pension plan in effect, good personnel policies, accommodation in residence if desired. For particulars apply to: The Director of Nurses, Lady Minto Hospital, Cochrane, Ontario. 7-30-1

Registered Nurses for 34-bed hospital, min. salary $320, 3-wk. vacation with pay, sick leave after 6-mo. service. **Certified Nurses Assistants** salary $220, 2-wk. vacation with pay. **All staff** — 5-day 40-hr. wk., 9 statutory holidays, pension plan & other benefits. Apply to: Superintendent, Englehart & District Hospital, Englehart, Ontario. 7-40-1

Registered Nurses. Applications and enquiries are invited for general duty positions on the staff of the Manitouwadge General Hospital. Excellent salary and fringe benefits. Liberal policies regarding accommodation and vacation. Modern well-equipped 33-bed hopsital in new mining town, about 250-mi. east of Port Arthur and north-west of White River, Ontario. Pop. 3,000. Nurses' residence comprises individual self-contained apts. Apply, stating qualifications, experience, age, marital status, phone number etc. to the Administrator, General Hospital, Manitouwadge, Ontario. Phone: TAylor 6-3251. 7-74-1

Registered Nurses for 30-bed active General Hospital, 45-mi. from Toronto. 40-hr. wk., O.H.S.C. and P.S.I., 50% payment by hospital, Hospitals of Ontario Pension Plan, 18-day sick leave/yr. For further information apply to: Superintendent, Community Memorial Hospital, Port Perry, Ontario. 7-109-1

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Registered Nurses & Certified Nursing Assistants for modern 75-bed hospital. Starting salaries — R.N.'S $310 per mo., C.N.A.'S $220 per mo. Single room accommodation available in the residence. Dryden (population 6,500) an industrial town, also center of extreme tourist area, is conveniently located midway between Winnipeg & the Canadian Lakehead. For further information regarding personnel policies, community activities, etc. please call or write: The Director of Nursing, Dryden District General Hospital, Dryden, Ontario. 7-36-1

Registered Nurses and Certified Nursing Assistants for new wing opening January 1st, 1963. Excellent personnel policies and employee benefits. Apply to: Director of Nursing, Memorial Hospital, Huntsville, Ontario. 7-59-1

Registered Nurses & Certified Nursing Assistants for 160-bed accredited hospital. Starting salary $320 & $220 respectively with regular annual increments for both. Excellent personnel policies including 5-day wk. Ontario hospital pension plan. Residence accommodation available. Assistance with transportation can be arranged. Apply: Director of Nurses, Kirkland & District Hospital, Kirkland Lake, Ontario. 7-67-1

Registered Nurses, general floor duty, rotating shifts. Modern residence accommodation. Basic salary: $350 with 6 monthly increments for 2 yrs. Apply to: Matron, Margaret Cochenour Memorial Hospital, Cochenour, Ontario. 7-29-1

Registered or Graduate Nurses for modern 100-bed hospital located in summer resort district, 40-mi. from Ottawa. Apply: Director of Nursing, Public Hospital, Smiths Falls, Ontario. 7-120-2

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General Duty Nurses for an accredited 66-bed hospital. Starting salary: $305. Excellent personnel policies, pension plan, residence accommodation only 10 min. from downtown Buffalo. Apply: Director of Nursing, Douglas Memorial Hospital, Fort Erie, Ontario. 7-45-1

General Duty Nurses for modern 100-bed hospital. Registered Nurses $315-$345 per mo., Graduates $250-$285; 40-hr. wk., benefits include accident, sickness & life insurance, hospital and medical insurance plans, & OHA Pension Plan. Apply: Miss Tillett, Director of Nursing, Leamington District Memorial Hospital, Leamington, Ontario. 7-69-1

General Duty Nurses for 100-bed modern hospital, southwestern Ontario, 32 mi. from London. Salary commensurate with experience & ability; $300 basic salary. Residence accommodation available. Pension plan. Apply giving full particulars to: The Director of Nurses, District Memorial Hospital, Tillsonburg, Ontario. 7-131-1

General Duty Nurses Male & Female & Certified Nursing Assistants (Immediately) for 86-bed hospital, 40-hr. wk., 8 statutory holidays & other employee benefits. Collingwood is situated on Georgian Bay & is noted as a vacationland with 7-mi. sand beach and great skiing on the Blue Mountains in winter. For further information apply: Director of Nursing Services, General and Marine Hospital, Collingwood, Ontario. 7-31-1

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Operating Room Nurse for modern 75-bed General Hospital, good personnel policies with consideration for past experience. For complete information, please write, wire or telephone to: The Director of Nursing, Dryden District General Hospital, Dryden, Ontario. 7-36-1A

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Operating Room Supervisor for modern, accredited 55-bed hospital. 40-hr. wk., 1-mo. vacation. Living accommodation available in new motel-style nurses' residence. Apply stating qualifications to: Superintendent, Barrie Memorial Hospital, Ormstown, Quebec. 9-52-1

Night Supervisor for Shriners Hospital for Crippled Children, excellent personnel policies. Apply: Miss Flora M. Lamont, Administrator, Tel.: 842-4464, Montreal, Que. 9-47-42

Registered Nurses and Certified Nursing Assistants for modern 55-bed General Hospital, salary $300 per mo., 5 semi-annual increases, 40-hr. wk., 4-wk. vacation. **Certified N.A.** starting salary $210, 3-wk. vacation, accommodation available in new motel-style residence. Apply: Superintendent, Barrie Memorial Hospital, Ormstown, Quebec. 9-52-1A

Middle Aged Registered Nurse (must be bilingual) with Geriatric experience for small Nursing Home. 8-hr. floor duty. Apply: Pavillon Kateri, 26 Strathyre Ave., City of La Salle 32, Quebec. Tel.: DO. 6-9090. 9-47-54

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Matron and Graduate Nurse for 8-bed hospital in Southern Sask. Salary range for Matron $358-$453; R.N. $300-$380. Qualifications & experience considered. Duties to commence Jan. 1/63. 3-wk. vacation plus statutory holidays, 40-hr. work wk., modern residence on grounds. Apply to: Mrs. D. L. Knops, Sec. Treas., Rockglen Union Hospital, Rockglen, Saskatchewan. 10-110-1

Medical, Surgical and Obs. Nurses for 81-bed hospital, in city of 6,000 to 7,000 pop. Two (2) new service wings opened 1961. SRNA policies closely followed. Apply: Administrator, St. Peter's Hospital, Melville, Saskatchewan. 10-82-1

Registered Nurse (immediately) for Union Hospital, Mossbank, Sask., with Dr. J. T. Stockings in attendance, salaries as per SRNA with increments & benefits. 40-hr. wk., fully modern nurses' residence, daily bus service to the city. Apply to: Mrs. A. Haug, Matron, Mossbank, Saskatchewan. 10-88-1

Registered Nurses for 23-bed hospital. Salary range: $300-$377. 3-wk. vacation a yr., 40-hr. per wk., 1 1/4 days per mo. sick leave, accumulative to 90 days, 9 statutory holidays. Apply to: Superintendent of Nurses, Union Hospital, Spiritwood, Saskatchewan. 10-121-1

General Duty Graduate Nurses (for pediatric & obstetric wards immediately) for 75-bed hospital. Starting salary: $295. 8-hr. day, 40-hr. wk., room & board available, if desired at the residence. Apply to: St. Therese Hospital, Tisdale, Saskatchewan. 10-124-1

General Duty Nurses, Saskatchewan registered, for 100-bed General Hospital, salary based on experience, with recognition for P.G. Courses & University training. Good personnel policies, residence accommodation & meals if desired. Apply to: Director of Nurses, Union Hospital, Weyburn, Saskatchewan. 10-135-2

U.S.A.

Registered Nurse, General Duty, 12 beds, 2 doctors, small town in southeastern Alaska. Write via airmail to: Superintendent, Bishop Rowe Hospital, Wrangell, Alaska. 15-2-1

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Registered Nurses for modern 374-bed JCAH fully accredited General Hospital. Located on beautiful San Francisco Peninsula, 20-min. drive from the heart of the city. Openings in all services. Excellent personnel policies. Many extra benefits and opportunities for advancement. Top salaries. Apply: Personnel Director, Peininsula Hospital, 1783 El Camino Real, Burlingame, California. 15-5-20

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Registered Nurses for private 258-bed hospital for men, women and children. Staff Nurse salaries from $355-$435, differentials for evenings, nights, communicable disease, operating room and delivery. Opportunities in all clinical areas. Holidays, vacations, sick leaves and health insurance. California registration required. Applications and details furnished on request. Contact: Personnel Director, Children's Hospital, 3700 California Street, San Francisco 18, California. 15-5-4

Registered Nurses General Duty for 230-bed approved teaching hospital, resort city. Starting salary $375 per mo. plus $22.50 shift differential, provision for housing allowance. Apply: Director of Nursing, Cottage Hospital, Santa Barbara, California. 15-5-39

Staff Duty positions (Nurses) in private 428-bed hospital. Liberal personnel policies and salary. Differential for evening and night duty. Write: Personnel Director, Hospital of The Good Samaritan, 1212 Shatto Street, Los Angeles 17, California. 15-5-38

General Duty Nurses (Immediate openings) for 181-bed modern, fully accredited hospital in central California. Good starting salary with periodic increases. 5 day, 40-hr. wk. Paid vacation, sick leave, holidays. Blue Cross available. Social Security. Apply: Personnel Director, Mercy Hospital, 2215 Truxtun Avenue, Bakersfield, California. 15-5-58

General Duty Staff Nurses for large General Hospital, located in college community, central California. Starting salary: $413 per mo. Excellent in-service education program, liberal fringe benefits, shift differential. Apply: Personnel Director, 530 Courthouse, Stockton, California. 15-5-36

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Staff Nurses for 300-bed General Hospital. Attractive personnel policies plus differential for specialties, afternoon and night duty. Opportunities for advanced education. Apply to: Director of Nursing Service, Kaiser Foundation Hospital, Oakland 11, California. 15-5-3C

Nurses for new 75-bed General Hospital. Resort area. Ideal climate. On beautiful Pacific ocean. Apply to: Director of Nurses, South Coast Community Hospital, South Laguna, California. 15-5-50

General Duty Nurses for various departments includling surgery for 72-bed hospital. Starting salary $375 per mo. with periodic increases and fringe benefits. College town, tourist area, ideal climate. Contact: Superintendent, Alamosa Community Hospital, Alamosa, Colorado. 15-6-1

Registered Nurses for 74-bed air-conditioned hospital, growing community. Starting salary: $330 per mo., fringe benefits, vacation, sick leave, holidays, life insurance, hospital insurance, 1 meal furnished. Write: Hendry General Hospital, Clewiston, Florida. 15-10-1

General Duty Nurses for 54-bed hospital, minimum starting salary $350 per mo., located near Miami and West Palm Beach. Apply: Director of Nurses, Belle Glade Memorial Hospital, Belle Glade, Florida. 15-10-3

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Graduate Nurses for 450-bed non-sectarian acute General Hospital with NLN fully accredited school of nursing. Liberal personnel policies include tuition aid for study at Western Reserve University. Opening of new main building has created attractive positions for Staff Nurses in medical, surgical, obstetric and pediatric divisions. Apartments available in immediate neighborhood. Apply: Miss Louise Harrison, Director of Nursing Service, Mount Sinai Hospital, 1800 East 105th Street, Cleveland 6, Ohio. 15-36-1D

Staff Nurses for modern 400-bed tuberculosis hospital, suburban Cleveland, Ohio. Monthly salaries start at $396 with semi-annual increments. Extra for night and relief duty, 5-day work wk., 3-wk. paid vacation, 6 paid holidays, liberal sick leave, comfortable accommodations in nurses' residence at low rate. Learn and earn at a progressive accredited hospital in a growing community. Write: Director of Nursing, Sunny Acres Hospital, Cleveland 22, Ohio. 15-36-1E

Registered Nurse (Scenic Oregon, vacation playground, skiing, swimming, boating & cultural events) for 295-bed teaching unit on campus of University of Oregon medical school. Salary starts at $372. Pay differential for nights & evenings. Liberal policy for advancement, vacations, sick leave, holidays. Apply: Multnomah Hospital, Portland 1, Oregon. 15-38-1

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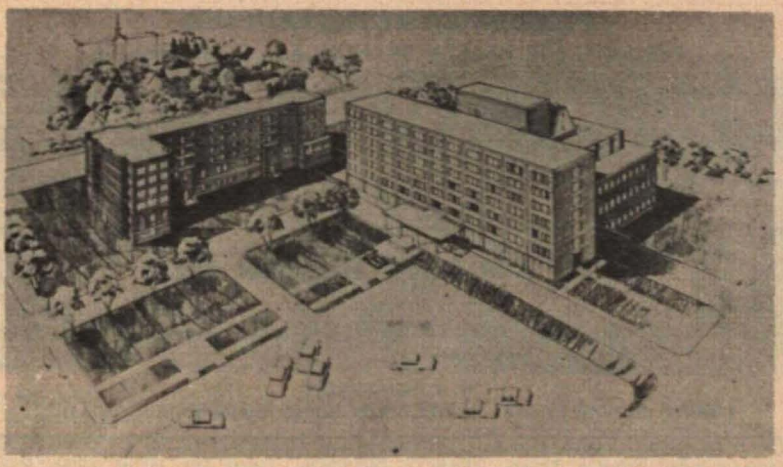

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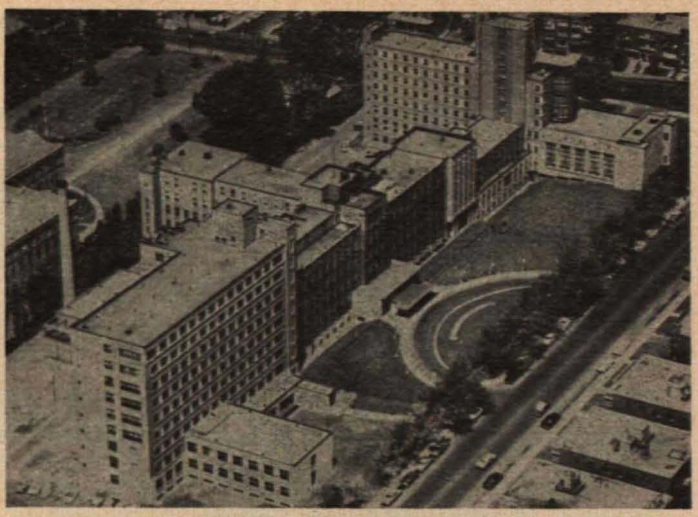
Staff Nurses (All Clinical Services) Base salary $350, opportunities for advancement, differential for 3-11 & 11-7 shifts, personnel policies, sick leave, retirement plan, 3-wk. vacation & laundry of uniforms. Orientation & in-service programs, housing available on campus. Apply: Director of Nursing Service, University of Texas Medical Branch Hospitals, Galveston, Texas. 15-44-5

Staff Nurses: University Hospital wants you — if you want a challenging and rewarding position in a modern expanding 320-bed teaching & research hospital located on campus. Opportunities in Clinical Research, Premature Center, Chronic Renal Program, Open Surgery, & Physical Medicine, in addition to the general services. Salary $360-$422, liberal benefits including tuition free courses after 6-mo. Contact: University Hospital Personnel, BB-314, Seattle, Washington. 15-48-2D

ONTARIO

Nursing Supervisor (1) General Duty Nurses (2) for modern new General Hospital 35-mi. from Toronto, 40-hr. wk., 8 statutory holidays and other employee benefits. For further information apply to: Superintendent, The Cottage Hospital (Uxbridge), Ontario. 7-135-1

JEWISH GENERAL HOSPITAL MONTREAL QUE.



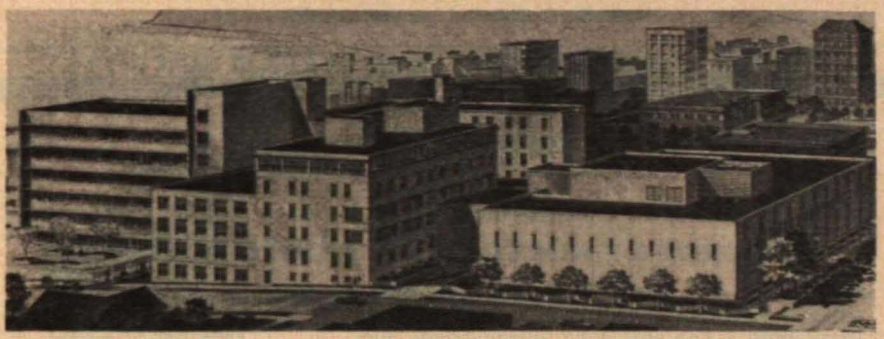
NURSING OPPORTUNITIES

In this modern 400-bed non sectarian hospital in Administration, Teaching, Staff Nursing. Certified Nursing Assistants also required. Openings in Psychiatry, Pediatrics, Obstetrics and Medicine and Surgery. Excellent personnel policies. Bursaries for post-basic courses in Teaching and Administration

For further information, please write:

Director of Nursing, JEWISH GENERAL HOSPITAL, 3755 Cote St. Catherine Rd., Montreal, Que.

COME WEST, YOUNG LADY!



OUR HOSPITAL IS ENJOYING AN EXCITING DEVELOPMENT WHICH IS CONSISTENT WITH THE ACTIVITIES AND ATTITUDES OF OUR CITY AND THE ENTIRE PACIFIC NORTHWEST. HERE IS A CHANCE TO BETTER YOURSELF PROFESSIONALLY AND ECONOMICALLY IN A COSMOPOLIAN AREA WITH AN IDEAL WORKING CLIMATE. PUGET SOUND, OUR LAKES AND MOUNTAINS OFFER UNSURPASSED RECREATIONAL FACILITIES.

Swedish Hospital—Seattle's largest and busiest hospital—now expanding again, offers . . .

- Highest standards of nursing care
- Top pay with specialty premiums ($355 - $400)
- Liberal fringe benefits
- Educational opportunities

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Director of Nursing Service

SWEDISH HOSPITAL

1212 Columbia, Seattle 4, Washington

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Gross salary $320 monthly with annual increments for 3 years to $350.

Until registration in Ontario is established — $295.

Rotating periods of duty — 40 hour week, 8 statutory holidays annually — Annual vacation 21 days after one year.

Annual sick time 12 days after one year, cumulative to 18 days. Hospitals of Ontario Pension Plan.

Ontario Hospital Insurance and Physicians' Services Incorporated, 50% payment by hospital.

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OWEN SOUND GENERAL AND MARINE HOSPITAL

OWEN SOUND, ONTARIO

Invites applications for the position of

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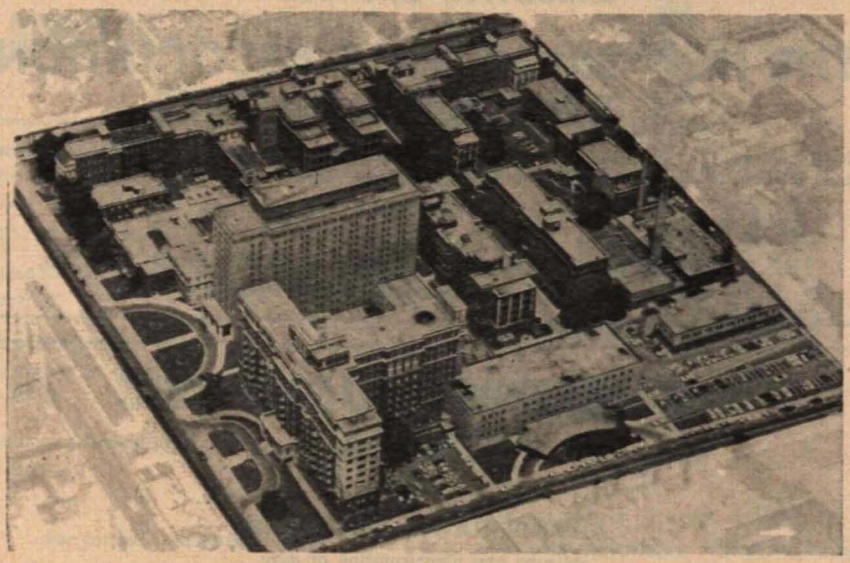
Modern 250-bed fully accredited General Hospital with a new School of Nursing and Residence, accommodating 90 students. Salary commensurate with qualifications and experience. Benefits include pension plan, group life insurance, hospitalization and medical coverage. State experience and postgraduate work. Position open on or about June 1, 1963.

Inquiries and applications to be forwarded to:

MR. J. G. CLARK, ADMINISTRATOR

TORONTO GENERAL HOSPITAL



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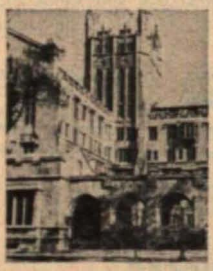
REGISTERED NURSES AND CERTIFIED NURSING ASSISTANTS

Planned Orientation Programme — Inservice Educational Programmes
Opportunity to gain additional knowledge in specialized fields of nursing
Excellent personnel policies
Salaries commensurate with prevailing current salaries in Metropolitan Toronto

For information or application write to:
DIRECTOR OF NURSING, TORONTO GENERAL HOSPITAL
101 College Street, Toronto 2, Ontario

COME TO CHICAGO



and the great
University of Chicago Hospitals

A great University in a Dynamic City offers Nurses opportunities for maximum wages while working with world-famous physicians and a professional staff of over a thousand.

Participate in campus and community activities . . . continue to learn at greatly reduced tuition . . . live in University-owned housing near the lake.

SALARIES: $410–$560
Differential for evenings and nights
Periodic increases
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ENJOY THE OPPORTUNITIES AND ADVANTAGES OF THE BIG CITY

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COURSES FOR R.N.'S N.Y. POLYCLINIC MED. SCH. & HOSP. — in heart of Manhattan — 6-mo. courses in: O.R. NURSING, OPD. NURSING, MED.-SURG. NURSING. Classes 4 times yrly: Mar., June, Sept., Dec. Room, meals, Medical Care & monthly cash stipend. Positions available to graduates of our Courses. For information write: Director of Nursing Education, 345 W. 50 St., N.Y.C., NEW YORK. 15-33-2A

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Qualifications: R.N. plus Baccalaureat Degree in Nursing. Master's Degree desirable. Demonstrated ability in Nursing Education and Administration. Salary Negotiable.

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requires

ADMINISTRATIVE SUPERVISOR

evening and night rotation of duty
Graduate Staff Nurses

For further information write:

THE DIRECTOR OF NURSING
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Director of Nursing and Nursing Supervisors

Required for the Children's Services
of the
VERDUN PROTESTANT HOSPITAL

This new unit will include a 20-bed service for emotionally disturbed adolescents and service for the mentally retarded. A director of Nursing for the service and senior supervisor for each of the two divisions is required. Preference will be given to senior personnel with university degrees or diplomas in teaching, administration and clinical supervision. Suitable candidates will also have teaching responsibilities and will be recommended for university appointments. Applications are invited from qualified persons who are interested in this field of service, and should be forwarded as soon as possible to:

The Personnel Manager
VERDUN PROTESTANT HOSPITAL
6875 LaSalle Boulevard, Verdun, Que.

REGISTERED NURSES AND LICENSED PRACTICAL NURSES

Accredited voluntary hospital. Brand new. Pleasant residential community 30 minutes from NYC, close to resort areas. Residence facilities. In-service training program. 40 hour week, sick benefits, paid vacation. Top salaries; added increments for education, training and experience.

Contact:

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NYACK HOSPITAL, NYACK, NEW YORK.

DIRECTOR OF NURSING

required

Immediately for active 24-bed modern hospital, situated in the heart of the Rocky Mountains 90 miles from Banff and Lake Louise. Must have O.R. experience and be eligible for B.C. registration.

Hospital is well equipped and fully staffed.

Superannuation, medical benefits. Accommodation available in attractive nurses' residence.

Salary according to experience and qualifications.

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ADMINISTRATOR,
WINDERMERE DISTRICT
HOSPITAL
INVERMERE, BRITISH COLUMBIA

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required by the

HAMILTON CIVIC HOSPITALS

Under general supervision to be responsible for planning, developing, directing and co-ordinating training programs for nursing department personnel.

QUALIFICATIONS:

(a) Graduation from an approved school of nursing, and eligible for registration in the Province of Ontario.

(b) The applicant must have a degree in nursing, previous experience in Nursing Service Administration, and demonstrated experience as an Instructor in a School of Nursing.

Salary range $94, to $110 per week. Vacation, sick leave and pension plans.

Apply in writing to:

DIRECTOR OF PERSONNEL
HAMILTON CIVIC HOSPITALS
BARTON STREET EAST
HAMILTON, ONTARIO.

THE CANADIAN RED CROSS SOCIETY

SEEKS

Registered Nurses willing to serve as volunteer Home Nursing Instructors in the Red Cross Branch in their own community.

and offers interesting and challenging positions in

OUTPOST NURSING
PUBLIC HEALTH NURSING
BLOOD TRANSFUSION SERVICE

Salaries are in proportion to experience and qualifications.

Transportation arranged under certain circumstances.

Bursaries available for postgraduate studies.

Group insurance, pension plan and other benefits.

For information please contact:

NATIONAL DIRECTOR,
NURSING SERVICES,
THE CANADIAN RED CROSS SOCIETY
95 Wellesley Street East,
Toronto 5, Ontario

WOODSTOCK GENERAL HOSPITAL

WOODSTOCK, ONTARIO

requires

MEDICAL CLINICAL TEACHER

Preferably with B.Sc.N. degree and experience.
Salary commensurate with qualifications and experience.

Apply to:

DIRECTOR OF NURSING
WOODSTOCK GENERAL HOSPITAL, WOODSTOCK, ONTARIO.

GRADUATE STAFF NURSES

required for

MEDICAL AND SURGICAL AREAS

University teaching hospital. Applicants should be eligible for Ontario Registration.

Personnel policies and further information may be obtained from:

DIRECTOR OF NURSING

KINGSTON GENERAL HOSPITAL, KINGSTON, ONTARIO

BROCKVILLE GENERAL HOSPITAL

BROCKVILLE, ONTARIO

SCHOOL OF NURSING

Invites applications for

TWO INSTRUCTORS

Requirements: University preparation in Nursing Education
Salary differential for degree

Apply to: **DIRECTOR OF NURSING**

OPERATING ROOM SUPERVISOR

Applications are invited from interested persons for the position of Operating Room Supervisor at the General Hospital, St. John's, Newfoundland.

A postgraduate course and experience is essential.

Duties to include overall direction of 12 room Operating Theatre plus a Recovery Room.

Fare paid to St. John's on the basis of a minimum of one year's service.

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DIRECTOR OF NURSING
GENERAL HOSPITAL
ST. JOHN'S, NEWFOUNDLAND.

REGISTERED NURSES

and

CERTIFIED NURSING ASSISTANTS

for

375-bed, fully accredited General Hospital. Registered Nurses salary $300 - $340 per month. Certified Nursing Assistants $200 - $230 per month.

For further information write:

DIRECTOR OF NURSING SERVICE
METROPOLITAN GENERAL HOSPITAL

WINDSOR, ONTARIO

Experienced, qualified

EDUCATIONAL DIRECTOR

and

NURSING INSTRUCTOR

required for long established School of Nursing.

* * *

71 students enrolled — General Hospital 150 beds.

7 hour day, 5 day week — 4 week's annual vacation.

Excellent personnel policies
Pension Plan — Sick Leave Allowance.

Salary commensurate with experience.

* * *

Scenic City of 65,000
100 miles from Montreal.

Good transportation facilities.

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Duties to commence August 1st, 1963

Apply:

DIRECTOR OF NURSING
SHERBROOKE HOSPITAL
SHERBROOKE, QUEBEC, CANADA

PROVINCE OF ALBERTA

EMPLOYMENT OPPORTUNITIES

GENERAL DUTY GRADUATE NURSE

PROVINCIAL MENTAL HOSPITAL
PONOKA
$300-$360

1250-bed active treatment mental hospital, conducting a Basic approved School of Nursing and Post Basic Course in Psychiatric Nursing. Room and board, if desired, $30 per month. Usual Public Service benefits apply.

Apply to:

DIRECTOR OF NURSING
PROVINCIAL MENTAL HOSPITAL
Ponoka, Alberta

JOSEPH BRANT MEMORIAL HOSPITAL

BURLINGTON, ONTARIO

228-bed hospital

Progressive community of 50,000

Located near Toronto, Hamilton and the U.S. Border.

Positions are available for

GENERAL DUTY NURSES

For information, write to the

Director of Nursing

GRADUATE STAFF NURSES

Opportunities for men and women on all services including metabolism, rehabilitation, psychiatry, recovery room, medicine, surgery, pediatrics, obstetrics, operating room, and emergency room. Well planned orientation and in-service programs, tuition-free courses at Western Reserve University after 3 months employment, low cost housing in nurses' residence. Liberal personnel policies with premium for evening and night tours of duty. Starting rate based on experience and enducation. Staff nurse salary range $385 to $425. Write for more information and the booklet "New Horizons in Nursing," to:

DIRECTOR OF NURSING, UNIVERSITY HOSPITALS OF CLEVELAND
University Circle, Cleveland 6, Ohio

MONTREAL CHILDREN'S HOSPITAL

invites applications from

GRADUATE NURSES
and
CERTIFIED NURSING ASSISTANTS

to fill vacancies on medical and surgical wards as well as specialty departments as Premature Surgery, Neuro-Surgery - Metabolism - Psychiatry - Out Patient Department - Operating Room and Intensive Care. Salaries in accordance with ANPQ recommendation, differential for Post-basic preparation. Good personnel policies. In-service program.

Write :

DIRECTOR OF NURSING, MONTREAL CHILDREN'S HOSPITAL
2300 TUPPER STREET, MONTREAL 25, QUEBEC

MEN REGISTERED NURSES

Two men Registered Nurses required by March to provide professional nursing care and health teaching in the home on a visit basis. Planned orientation and ongoing staff education program. Personnel policies include 4 weeks vacation, uniform allowance, pension plan, agency car or car allowance. Enquiries welcomed.

DISTRICT DIRECTOR
VICTORIAN ORDER OF NURSES (TORONTO BRANCH)
281 SHERBOURNE STREET
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WA. 1-3184

NURSES

If you desire to practise your profession in a modern and scientific hospital, that has 21 specialties and 1,050 beds, join the nursing staff of

NOTRE DAME HOSPITAL

Generous salaries, according to qualifications, with periodic increases. Differential for evening and night duty, 10 statutory holidays. Vacation based on date of employment. Pension plan. In-service education program. Recreational center

For information, write to:

LA DIRECTRICE DU NURSING
HOPITAL NOTRE-DAME, 1560 est, rue Sherbrooke, Montréal 24

OPPORTUNITIES FOR RECENT GRADUATES

Staff positions will be available for Registered Nurses with special interest in rehabilitation and medical nursing. Those showing aptitude will have an excellent opportunity for early advancement to fill newly created posts which command the increases in remuneration as recommended by the Registered Nurses' Association of Ontario.

Starting monthly rate $325-$345. Private residence accommodation with adjoining bath available. Full maintenance $40 monthly. Good location. Transportation advanced if requested.

Participation in clinical conferences, and in-service education program encouraged.

For information contact
The Director of Nursing,

The Queen Elizabeth Hospital,
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TORONTO 3, Ont.

REGISTERED NURSES
and
CERTIFIED NURSING ASSISTANTS
required for

FIVE SUMMER CAMPS

STRATEGICALLY LOCATED
THROUGHOUT ONTARIO
AND NEAR
OTTAWA - LONDON
COLLINGWOOD
PORT COLBORNE
KIRKLAND LAKE

Apply in writing to:

MISS HELEN WALLACE, REG'D. N.
Supervisor of Camps
ONTARIO SOCIETY FOR CRIPPLED CHILDREN
350 Rumsey Road
P.O. Box 1700, Station "R"
Toronto 17, Ontario

REGISTERED NURSES

and

CERTIFIED NURSING ASSISTANTS

required for modern 400-bed hospital.

Good salaries and personnel policies. New 13 storey staff apartment for nurses including married couples — one block from hospital — furnished and unfurnished suites (including broadloom and drapes) — rates reasonable — convenient to downtown.

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Operating Room Nurses

General Staff Nurse positions available in General Operating Rooms (general surgical, cardiac, neuro-surgical, plastic, orthopedic, ear, nose and throat, and urology). Positions also in Gynecological and Ophthalmological operating rooms. Salary commensurate with experience, excellent additional benefits including refund of tuition up to six points per semester.

For further information write to:

DIRECTOR, NURSING SERVICE
THE JOHNS HOPKINS HOSPITAL
BALTIMORE 5, MARYLAND

HEAD NURSE OPERATING ROOM

Postgraduate certificate required for charge position in this 110-bed hospital in Northwestern British Columbia.
RNABC personnel and salary policies in effect plus $15 per month.
Comfortable modern nurses' residence available - Full maintenance $50 per month.

For further information apply to:

DIRECTOR OF NURSING, PRINCE RUPERT GENERAL HOSPITAL
Prince Rupert, British Columbia

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Starting Salary $330 per month - Allowance for experience - Enquiries invited - Personnel Policies on request - 40 Hour Week - 9 statutory Holidays - Room and Board - Nurses' Residence $45 per month
New Hospital to be completed very soon

Apply to: Mrs. G. AUGER
DIRECTOR OF NURSING, LITTLE LONG LAC HOSPITAL, GERALDTON, ONTARIO

REGISTERED NURSES
and
CERTIFIED NURSING ASSISTANTS

are invited to enquire re: employment opportunities for all departments of new 140-bed hospital. Good personnel policies, O.H.A. Pension Plan.

Enquire:

DIRECTOR OF NURSING
ROSS MEMORIAL HOSPITAL
Lindsay, Ontario

REGISTERED NURSES
and
CERTIFIED NURSING ASSISTANTS

required for

82-bed hospital when expansion complete Sept. 1962. Situated in the Niagara Peninsula. Transportation assistance.

For salary rates and personnel policies apply to:

DIRECTOR OF NURSING
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GENERAL DUTY NURSES

for

Chest Hospital in centre of Montreal
Good Personnel Policies

Apply:

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QUEENSWAY GENERAL HOSPITAL

requires

REGISTERED NURSES
for Fall vacancies

Liberal personnel policies

Apply:

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QUEENSWAY GENERAL HOSPITAL
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THE McKELLAR GENERAL HOSPITAL

SCHOOL OF NURSING

will require the following Instructors in the summer of 1963:

(1) Basic Nursing Instructor
(1) Surgical Nursing Instructor
(1) Medical Nursing Instructor
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Salary scale is good and so are the Personnel Policies.

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DIRECTOR OF NURSING
McKELLAR GENERAL HOSPITAL
FORT WILLIAM, ONTARIO.

REGISTERED NURSES

For Modern 52-Bed Hospital in the Province of Quebec. Prominent resort area, modern new Nurses' Residence, beautifully furnished. 40 hour week and statutory holidays. Three weeks leave after one year's service.

$300 per month plus $20 night duty differential, $10 a month increase after six months' service and another $10 per month after one year's service. Phone: 647-2211, 2212, 2213, 2214.

Apply:

Director of Nursing
Pontiac Community Hospital
Box 280, Shawville, Quebec

CAMP DIRECTORS

Registered Nurses to direct summer camps for crippled children — June, July, August. Preference given to applicants with supervisory experience.

For further information apply to:

SUPERVISOR OF CAMPS

Ontario Society for Crippled Children,
Box 1700, Postal Station "R",
350 Rumsey Road, Toronto 17,
Ontario.

CHILDREN'S HOSPITAL OF WASHINGTON, D.C.

OFFERS

Registered Nurses a 16-wk. supplementary program in pediatric nursing. Admission dates, January 2, May 7, September 4, 1962; January 7, 1963.

For complete information write to:

DIRECTOR OF NURSING
2125 - 13th STREET, N.W.,
WASHINGTON 9, D.C.

WOODSTOCK GENERAL HOSPITAL

REQUIRES

TWO GENERAL STAFF NURSES

for
OPERATING ROOM
Preferably with experience

For further information write:

DIRECTOR OF NURSING
WOODSTOCK GENERAL HOSPITAL
WOODSTOCK, ONTARIO.

For Summer Sports ! !
For Winter Sports ! !

"Come to the Lakehead"

THE McKELLAR GENERAL HOSPITAL

needs progressive nurses and will prepay costs of transportation for those nurses who will remain on staff for one year. Personnel policies are good — the people are friendly.

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McKELLAR GENERAL HOSPITAL
FORT WILLIAM, ONTARIO

PSYCHIATRIC NURSING STAFF

required for

NEW MENTAL HEALTH DIVISION
of
ROYAL OTTAWA SANATORIUM
immediately

For further particulars write:

Director of Nursing
Royal Ottawa Sanatorium
Ottawa, Ontario

REGISTERED NURSES

For general duty in 120-bed Radiotherapy Centre, affiliated with University of Toronto.

Please apply to:

Director of Nursing
Princess Margaret Hospital
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Toronto 5

OTTAWA CIVIC HOSPITAL

requires

GENERAL STAFF NURSES

for

OPERATING ROOM
MEDICAL
SURGICAL
OBSTETRICAL AND PSYCHIATRIC } DEPARTMENTS

Apply

EDITH G. YOUNG, REG. N.,
Assistant Director and Administrator of the Department of Nursing

HEAD NURSE REQUIRED

For Labor and Delivery Room area
40-bed Obstetrical Unit,
in 250-bed General Hospital.

Apply:

Director of Nursing
SUDBURY MEMORIAL HOSPITAL
Sudbury, Ontario

EDUCATIONAL OPPORTUNITIES

DALHOUSIE UNIVERSITY

School of Nursing

Degree Course in Basic Professional Nursing

Candidates for the degree of Bachelor of Nursing are required to complete 2 years of university work before entering the clinical field, and one year of university work following the basic clinical period of 30 months. On completion of the course the student receives the **Degree** of Bachelor of Nursing and the **Professional Diploma** in either Teaching in Schools of Nursing or Public Health Nursing.

Degree Course for Graduate Nurses

Graduate nurses who wish to obtain the degree of Bachelor of Nursing are required to complete the three years of university work.

Diploma Courses for Graduate Nurses

(a) Public Health Nursing
(b) Teaching in Schools of Nursing
(c) Nursing Service Administration

For further information apply to:

DIRECTOR, SCHOOL OF NURSING
DALHOUSIE UNIVERSITY, HALIFAX, N.S.

UNIVERSITY OF BRITISH COLUMBIA

School of Nursing

DEGREE COURSE IN BASIC NURSING

DEGREE COURSE FOR GRADUATE NURSES

Both of these courses lead to the B.S.N. degree. Graduates are prepared for public health as well as hospital nursing positions.

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1. **Public Health Nursing.**
2. **Administration of Hospital Nursing Units.**

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The Director, SCHOOL OF NURSING
UNIVERSITY OF B.C.,
VANCOUVER 8, B.C.

UNIVERSITY OF SASKATCHEWAN

SCHOOL OF NURSING

in cooperation with

UNIVERSITY HOSPITAL

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Teaching and Supervision. **To prepare for positions in teaching and supervision in Schools of Nursing.**

Public Health Nursing. **To prepare for staff positions in all types of public health nursing agencies.**

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Credits earned may be applied toward the degree of Bachelor of Science in Nursing.

PROGRAMS FOR HIGH SCHOOL GRADUATES

Bachelor of Science in Nursing. **Students with senior matriculation may enroll in a combined academic and professional program.**

Diploma in Nursing. **The School also conducts a three-year hospital program.**

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Offers the following opportunity for advanced preparation to qualified Registered Graduate Nurses:

A six month Clinical Course

in

Operating Room Principles and Advanced Practice.

The course commences in September of each year. Maintenance is provided, and a reasonable stipend is given each month. Enrolment is limited to a maximum of ten students.

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THE DIRECTOR OF NURSING

700 William Avenue, Winnipeg 2.

WILLS EYE HOSPITAL

Philadelphia, Penna.

The largest eye hospital in the United States offers a six-month course in *Nursing care of the Eye* to *Graduates of Accredited Nursing Schools*, Operating Room Training is scheduled in the course.

- **Full maintenance and a stipend of $237 per month for the first three months, $247 per month for the last three months, plus maintenance.**
- ***Registration Fee is* $20**
- **Course starts *September 16th & March 16th*. Ophthalmic Nurses in great demand for hospital eye departments, operating rooms & ophthalmologist's offices.**

For information write to:

Director of Nurses,
WILLS EYE HOSPITAL,
1601 Spring Garden Street,
Philadelphia 30, Penna.

ROYAL VICTORIA HOSPITAL

SCHOOL OF NURSING

MONTREAL, QUEBEC

Postgraduate Courses

1. (a) Six month clinical course in Obstetrical Nursing.

   Classes—September and February.

   (b) Two month clinical course in Gynecological Nursing.

   Classes following the six month course in Obstetrical Nursing.

   (c) Eight week course in Care of the Premature Infant.

---

2. Six month course in Operating Room Technique and Management.

   Classes—September and March.

---

3. Six month course in Theory and Practice in Psychiatric Nursing.

   Classes—September and March.

For information and details of the courses, apply to:—

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Royal Victoria Hospital
Montreal, P.Q.

QUEEN'S UNIVERSITY

SCHOOL OF NURSING

COURSES OFFERED

Undergraduate

Degree Course, B.N.Sc.,

Graduate Nurse

(a) Degree Course, two years.
(b) Diploma Courses, one year.
Public Health Nursing

Teaching and Supervision.

Entrance requirement for all courses: Senior Matriculation

For information apply to:

DIRECTOR
SCHOOL OF NURSING
QUEEN'S UNIVERSITY
Kingston, Ontario

A COURSE

in Advanced Operating Room Technique and Management

is offered by

THE MONTREAL GENERAL HOSPITAL

to

Qualified Registered Nurses

Classes of 6 months' duration are admitted March and September and are limited to 6 students.

For further information write to:

THE DIRECTOR OF NURSING
THE MONTREAL GENERAL HOSPITAL
MONTREAL 25, QUE.

MONTREAL NEUROLOGICAL INSTITUTE

McGILL UNIVERSITY

Graduate Course in

1) Neurological and Neurosurgical Nursing
2) Operating Room Technique

CLASSES: Mar. 1 and Sept. 1

Students may live in or out

POSITIONS AVAILABLE

General Staff Nurses
(including operating room)

For further information apply:

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KENTVILLE, N.S.

Offers to Graduate Nurses a Three-Month Course in *Tuberculosis Nursing*, including Immunology, Prevention, Medical and Surgical Treatment.

1. **Full series of lectures by Medical and Surgical staff.**
2. **Demonstrations and Clinics.**
3. **Experience in Thoracic Operating Room and Postoperative Unit.**
4. **Full maintenance, salary and all staff privileges.**

For information apply to:

DIRECTOR OF NURSING
NOVA SCOTIA SANATORIUM
KENTVILLE, N.S.

CAREER ADVANCEMENT FOR NURSES

Nurses with advanced education for leadership are needed urgently throughout Canada.

Assumption University of Windsor offers special opportunities for

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